2

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

A MANUAL FOR COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING ON HIV AND AIDS HEALTH SERVICES

Second Edition

NATIONAL AIDS CONTROL PROGRAMME (NACP)
June 2014

TANZANIA

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

A MANUAL FOR COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING ON HIV AND AIDS HEALTH SERVICES

Second Edition

NATIONAL AIDS CONTROL PROGRAMME (NACP)
June 2014

A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services
First Edition 2010
Second Edition 2014

National AIDS Control Programme (NACP)
P.O. Box 11857, Dar es Salaam
Tanzania

Tel: +255 22 2131213
Fax: +255 22 2138282
Website: www.nacp.go.tz

ISBN 978-9987-650-82-8

This publication was developed and published with the support from the Japan International Cooperation Agency (JICA). Copies can be obtained from the NACP.

Table of Contents

Acknowledgements

This manual with accompanied tools is a product of the collaborative efforts of many individuals and organizations. The process of revising the document was facilitated by a reviewing team of the National AIDS Control Programme (NACP), which was led by Dr. A. Ramadhani and Dr. P. E. Mwidunda and coordinated by Mr. N. Kadoi. The MoHSW commends the team for its dedicated work.

The MoHSW would also like to express her sincere appreciation to the Japan International Cooperation Agency (JICA) for their continuous and generous support. Appreciation goes to all organizations that participated in the review and revision of the document including MOHSW/RCH, Regional Health Management Teams of Dodoma, Iringa, Mbeya and Pwani, Council Health Management Teams of Chamwino, Kibaha Town, Kongwa, Mafia, Mkuranga, Mpwapwa and Temeke, Partners such as MDH, DoD Mbeya, Tunajali, IntraHealth, Jhpiego, PharmAccess and World Health Organization (WHO).

Finally, as it is not possible to mention all those who contributed to development of this document, the MoHSW wishes to acknowledge the contribution of every expert who participated in one way or another in the entire process of preparing the second edition of the document.

DR. NEEMA RUSIBAMAYILA
DIRECTOR OF PREVENTIVE SERVICES

JULY 2014

Foreword

The first edition of "A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services" with comprehensive supportive supervision and mentoring tools was published in March 2010. Since then some new approaches in HIV prevention have been introduced to the country.

The Ministry of Health and Social Welfare (MoHSW) launched the Elimination of Mother to Child Transmission of HIV (eMTCT) Strategy 2012-2015 in 2012 to reduce new HIV infections in children with the introduction of Option B+ approach. Voluntary Medical Male Circumcision (VMMC) was introduced as an evidence-based HIV prevention approach in three pilot regions in 2009 and has been set as a priority strategy and scaled up in twelve regions.

The government has also developed The Third National Multi-sectoral Strategic Framework for HIV and AIDS (NMSF III) for the period of 2013/14 – 2017/18 and the Health Sector HIV and AIDS Strategic Plan III 2013-2017 (HSHSP III), which align with the new UNAIDS strategic directions with an ambitious vision: Zero New Infections, Zero AIDS-related Deaths and Zero Discrimination.

This second edition accommodated all the new developments in the health sector HIV and AIDS prevention, care and support services in Tanzania. The contents of the document have been also aligned with the Training Package of the Comprehensive Supportive Supervision and Mentoring for HIV and AIDS Health Services developed in 2011.

As it was mentioned in the foreword of the first edition, the manual and the tools should be recognised as "living documents" that needs to be reviewed and revised as challenges and new approaches/interventions continuously emerge in the field of HIV and AIDS. I therefore reiterate that all users of the manual and the tools, to provide feedbacks, to address the emerging needs and to further improve the document.

The MoHSW recommends this manual to be used by RHMTs, CHMTs as well as all Implementing Partners in the planning and implementation of the supportive supervisions as well as mentoring activities to ensure that the quality of HIV and AIDS services is improved.

DR. DONAN W. MMBANDO
CHIEF MEDICAL OFFICER

JULY 2014

Acronyms

A&B	Abstinence and Being Faithful
AIDS	Acquired Immunodeficiency Syndrome
AMO	Assistant Medical Officer
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
AZT	Zidovudine
BCC	Behaviour Change Communication
C&T	Care and Treatment
CBO	Community Based Organization
CCHP	Comprehensive Council Health Plan
CDC	Center for Disease Control and Prevention
CHMT	Council Health Management Team
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinator
DBS	Dried Blood Spot
DED	District Executive Director
DMO	District Medical Officer
DNA PCR	Deoxyribonucleic Acid Polymerase Chain Reaction
DRCHCo	District Reproductive and Child Health Coordinator
EGPAF	Elizabeth Glazier Paediatric AIDS Foundation
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith Based Organization
FEFO/FIFO	First Expired First Out / First In First Out
FHI	Family Health International
5S	Five S (Sort, Set, Shine, Standardize and Sustain)
FP	Family Planning
HBC	Home Based Care
HSPs	Health Service Providers
HF	Health Facility
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
HSHSP	Health Sector HIV and AIDS Strategic Plan
ICAP	International Centre for AIDS Care and Treatment Program
IEC	Information, Education and Communication
IMAI	Integrated Management of Adult and Adolescent Illness
IPC	Infection Prevention Control
IPT	Isoniazid Preventive Therapy
I-TECH	International Training & Education Center on Health
ITN	Insecticide Treated Net
JICA	Japan International Cooperation Agency
MMAM	Mpango wa Maendeleo ya Afya ya Msingi (Primary Health Care Service Development Programme)
MCH	Maternal and Child Health
MDGs	Millennium Development Goals

MO	Medical Officer
MOHSW	Ministry of Health and Social Welfare
M&E	Monitoring and Evaluation
NACP	National AIDS Control Programme
NEHSHIP	National Essential Health Sector HIV and AIDS Interventions Package
NGO	Non-Governmental Organization
NMSF	National Multi-Sectoral Strategic Framework for HIV/AIDS
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor
OIs	Opportunistic infections
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHDP	Positive Health Dignity and Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPP	Public – Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RRCHCo	Regional Reproductive and Child Health Coordinator
SOC	Standards of Care
SOPs	Standard Operating Procedures
SS	Supportive Supervision
STIs/RTIs	Sexually Transmitted Infections and Reproductive Tract Infections
TACAIDS	Tanzanian Commission for AIDS
TB	Tuberculosis
TB/HIV	Tuberculosis and HIV Co-infection
TFDA	Tanzania Food and Drug Authority
THIS	Tanzania HIV and AIDS Indicator Survey
THMIS	Tanzania HIV AND AIDS and Malaria Indicator Survey
UNAIDS	United Nations Joint AIDS Programme
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
VHWs	Village Health Workers
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZHRCs	Zonal Health Resource Centres

Chapter 1: Background

01

1.1 HIV Epidemic in Tanzania

Since the first case of Acquired Immunodeficiency Syndrome (AIDS) in Tanzania was reported in 1983, AIDS has evolved into an epidemic. The mainland Tanzania faces a generalized Human Immunodeficiency Virus (HIV) epidemic, with an estimated 5.3% of the mainland population aged 15-49 infected with HIV according to the Tanzania HIV and AIDS and Malaria Indicator Survey 2011-12 (2013). The prevalence is higher among women (6.3%) than men (3.9%). A statistically significant decline in the overall HIV prevalence has been observed from 7.0% of the 2003-04 Tanzania HIV Indicator Survey and 5.8% of the THMIS 2007-08. The decline is significant among men as well. However, it is not significant among women.

It is also notable that the prevalence among adolescents (15-19) was unchanged (1.0%) from the previous survey. There are large variations in HIV prevalence by regions. The highest HIV prevalence rate is found in Njombe[1] region (14.8%), followed by Iringa (9.1%) and Mbeya (9.0%). Regions with the lowest HIV prevalence include Manyara (1.5%) and Tanga (2.4%). There continues to be a significant difference between urban and rural areas of the Mainland, 7.2% and 4.3% respectively.

According to the 2012 estimates by the UNAIDS, 1.5 million (1.3 – 1.6 million) Tanzanians (1.2 million adults and 230,000 children) are living with HIV infection, 80,000 (69,000 – 94,000) people died of AIDS, 83,000 (69,000 – 100,000) people were newly infected in a total population of 45 million. The social, economic, and environmental impact of the pandemic is sorely felt as estimated number of orphans aged 0 ‑ 17 due to AIDS is 1.2 million (UNAIDS, 2013). Close to 85% of HIV transmission in Tanzania occurs through heterosexual contacts, less than 6% through mother-to-child transmission, and less than 1% through blood transfusion.

1.2 National Response to the HIV Epidemic

Between 1986 and 2002, the National Response was coordinated through successive short and medium term plans under the leadership of the National AIDS Control Programme (NACP) of the Ministry of Health. In 2001, an Act of Parliament established the Tanzanian Commission for AIDS (TACAIDS) to lead the multi-sectoral national response under the Prime Minister's Office. In November of the same year, the National Policy on HIV/AIDS was developed and approved by the Parliament. In January 2003, the National Multi-Sectoral Strategic Framework for HIV/AIDS (NMSF) was approved.

The Care and Treatment Plan was launched in 2004. HIV care and treatment clinics (CTCs) have been set up in both public and private hospitals, health centres and dispensaries. According to the NACP CTC Database (2014), the number of health facilities providing HIV care and treatment services has expanded to 1,209 as of December 2013. HIV care and treatment services have enrolled 1,366,402 clients, out of whom 850,274 patients have ever

[1] *It is one of the new administrative regions, separated from Iringa region in 2012.*

started antiretroviral therapy (ART), out of whom 512,555 are currently on ART as of December 2013. This can be attributed to the increased access to ART, HIV testing and counselling (HTC), prevention of mother to child transmission (PMTCT) services, collaborative TB/HIV services, other HIV and AIDS services and the impact of periodic HIV testing campaigns.

Various national documents such as two multi-sectoral strategic frameworks and two health sector strategic plans were developed in line with the national development vision and strategic plans as well as international commitments and goals including Millennium Development Goals (MDGs) [2], the United Nations General Assembly Special Session (UNGASS) Declaration[3] and the UNAIDS's Universal Access[4] to Comprehensive Prevention, Care, Treatment and Support Services. Recently, Tanzania developed the Elimination of Mother to Child Transmission of HIV Plan 2012-2015, the Third National Multi-sectoral Strategic Framework for HIV and AIDS (NMSF III) for the period of 2013/14 – 2017/18 and the Health Sector HIV and AIDS Strategic Plan III 2013-2017 (HSHSP III), aligning with the new UNAIDS strategic directions with an ambitious vision: Zero New Infections, Zero AIDS-related Deaths and Zero Discrimination. These new documents indicate the government's continuing commitment to combating HIV and AIDS, taking into account steady decline of funding for HIV and AIDS due to changing global economic environment.

1.3 HIV and AIDS Interventions

The National Essential Health Sector HIV and AIDS Interventions Package (NEHSHIP) describe all HIV and AIDS interventions, services and activities to be provided at all levels of the health care system in Tanzania. The interventions fall into the three categories as follows:

a) Prevention of HIV Transmission
Prevention of Mother to Child Transmission (PMTCT), Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI), Voluntary Medical Male Circumcision (VMMC), Safe Blood, Workplace Interventions, Youth Friendly services and Positive Health Dignity and Prevention (PHDP).

b) HIV Treatment, Care and Support
Antiretroviral Therapy (ART), Collaborative Tuberculosis (TB)/HIV and Community-Based HIV and AIDS Services (CBHS)

c) Cross Cutting Services
Diagnostic (laboratory and imaging), Pharmaceutical services HIV Testing and Counselling (HTC: Voluntary or Client-Initiated Counselling and Testing, Provider-Initiated Testing and

---

[2] *The Millennium Development Goals are a United Nations initiative where heads of state promised "eradicate poverty, promote human dignity and equality and achieve peace, democracy and environmental sustainability at the beginning of the millennium." In order to achieve this, eight MDGS were developed for 2015 including the "combating of HIV/AIDS and other diseases".*
[3] *UNGASS is the United Nations General Assembly Special Session on HIV/AIDS. Biannually, Tanzania reports to UNGASS on a series on indicators to show progress in reaching the agreed goals.*
[4] *Universal Access is the new UNAIDS theme of ensuring everyone who needs to access services related to HIV and AIDS across the themes of prevention, care and treatment and impact mitigation.*

Counselling, and Home Based Counselling and Testing), Stigma and Discrimination reduction, Condom Programming and Nutrition Support and Information, Education and Communication (IEC)/Social and Behaviour Change Communication (SBCC).

In this document, however, the focus is on the following key interventions/services and their Monitoring and Evaluation (M&E) and IEC/SBCC components: PMTCT, STIs/RTIs, ART, TB/HIV, HBC, HTC, VMMC, laboratory and pharmaceutical services.

1.4 Health Care Delivery System in Tanzania

The Mainland Tanzania is divided into 25 health service administrative regions and 163 Councils as of December 2013. Tanzania has adapted a decentralized system of Government including health services. In 2007 the MOHSW developed the Primary Health Care Service Development Programme 2007-2017 (known in Kiswahili as MMAM i.e. Mpango wa Maendeleo ya Afya ya Msingi) to accelerate the provision of primary health care services for all. The main areas of focus are on strengthening the health systems, rehabilitation, human resource development, the referral system, increasing health sector financing and improving the provision of medicines, equipment and supplies (MOHSW, 2007). Through this programme each village in the country will have a dispensary and each administrative ward a health centre. As a result, numbers of health facilities and health professionals have been increasing.

Figure 1 depicts the structure of the health care system organized in a pyramidal pattern. According to the structure, a dispensary is the lowest formal health system structure, caters for 6,000 to 10,000 people and may serve one or more villages. Service provision is limited to managing common illnesses as outpatients on one hand and to provision of health preventive/ promotion services on the other. According to the District Health Information System of the MOHSW (2014), as of May 2014 there are 5,960 dispensaries country wide.

A health centre, on the other hand, caters for approximately 50,000-100,000 people residing in one administrative ward. Apart from the outpatient and preventive/promotion services, a health centre also provides inpatient services with 24 beds for female and male medical ward, obstetrics, operating theatre and diagnostic services. As of May 2014 there are 717 health centres operating in the country.

Each administrative district is served by a district hospital. District hospitals form an integral part of the PHC system. They provide clinical services to inpatients and outpatients referred from primary health facilities and other hospitals within the district. District hospitals may differ in size and bed capacity but are generally capable of managing common medical, obstetric, paediatric and surgical emergencies.

Regional Hospitals are designated health facilities which are better equipped and staffed (have one or more specialist doctors) and form the secondary referral level in the pyramid, providing specialized clinical services. Plans are underway to ensure that all regions have specialists in the major clinical disciplines: surgery, medicine, obstetrics and gynaecology, and paediatrics.

There are currently 261 hospitals including consultant hospitals and private ones as of May 2014 country wide.

Consultant Hospitals are tertiary-level multi-specialist hospitals. There are four hospitals i.e. Muhimbili National Hospital (MNH), Mbeya Referral Hospital, Bugando Medical Centre and Kilimanjaro Christian Medical Centre (KCMC) referral/consultant hospitals. Of the four, the MNH offers services of a wider range of specialized services. Patients who may not be adequately managed at these hospitals are referred outside Tanzania.

Specialized hospitals offer specialist services of one kind: Muhimbili Orthopaedic Institute (MOI) for orthopaedics and traumatology, Ocean Road Cancer Institute (ORCI) for Cancer, Mirembe Psychiatric Hospital for mental health and Kibong'oto Hospital for tuberculosis.

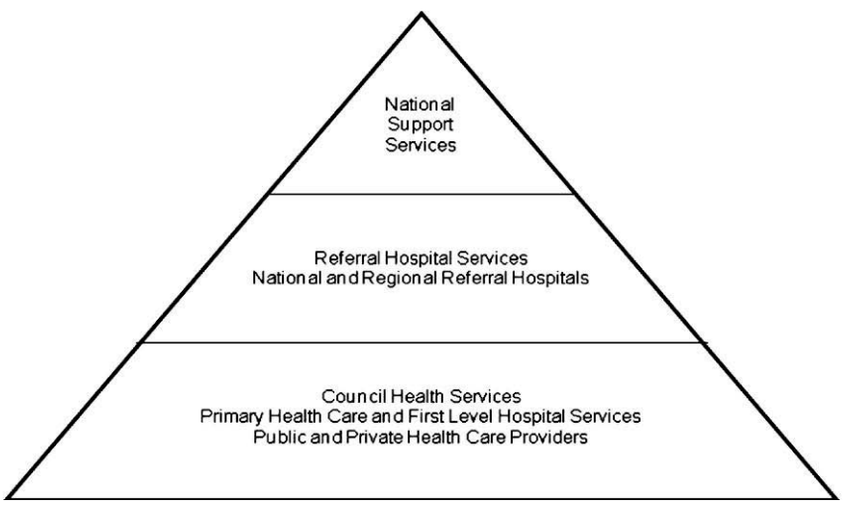

Figure 1. Health Services Structure in Tanzania (MOHSW, 2009)

1.5 Situation Analysis of Supportive Supervision and Mentoring in Tanzania

The National AIDS Control Programme (NACP) with the support of the Japan International Cooperation Agency (JICA) and International Training & Education Centre on Health (I-TECH) conducted a situation analysis on supportive supervision and mentoring in Tanzania between June and August 2009 (MOHSW, 2009). The overall objective was to assess the status of supportive supervision and mentoring activities with respect to HIV and AIDS health services at all levels. Information on supportive supervision and mentoring was collected from the national, regional, district and health facility levels. The study population included programme managers, focal persons for HIV and AIDS interventions and partners at national, regional, district and facility levels. Four regions were selected by the NACP based on the reporting rates of HIV Care and Treatment and Voluntary Counselling and Testing (VCT) services. These were Mtwara, Iringa, Kigoma and Manyara. In addition, data was collected from corresponding referral hospitals i.e. Muhimbili National Hospital and Mbeya Referral Hospital. Rombo and Monduli districts in Kilimanjaro and Arusha regions respectively were included in the study because of their experience in implementing mentoring activities.

1.5.1 Summary of Findings:

The findings are grouped into providers, tools and documents, implementation capacity of supervisors and mentors, knowledge and perception of health care workers, achievements, challenges and key recommendations.

Actors currently involved in supportive supervision and mentoring of HIV and AIDS health services:
At the national level, supportive supervision is vertically provided by programme administrators and partners while at the regional and district levels, it is done by Regional Health Management Teams (RHMTs), Council Health Management Teams (CHMTs) and focal persons of HIV related health services. A formal mentoring programme is not yet in place but some care and treatment partners such as EGPAF, AIDS Relief and ICAP have taken the initiative to provide mentoring services in their respective regions. There are not clear guidelines on supervision such as frequency, tasks to be accomplished and mechanisms for follow up on recommendations. Actual practice varies from one HIV intervention to another and from one implementing partner to the other. Similarly, mentoring practice lacked clear guidance.

Tools and documents used in supportive supervision and mentoring:
Differences were observed in tools/checklists and documents used in supportive supervision and mentoring. Some Programme staff, RHMTs, CHMTs and Partners adopted the national supportive supervision checklists while others made modifications of checklists to suit their needs.

Implementation capacity of supervisors and mentors:
Although some partners in Kigoma and Mtwara were providing 'some' supervision-related training, most of the supervisors had not been formally trained nor were NACP staff. In the case of clinical mentoring, ICAP and EGPAF took initiatives to prepare the clinical mentors. In fact, EGPAF has a 5-day district clinical mentors training package.

Knowledge and perception of supervisees and mentees on prior supportive supervision and mentoring:
Very few Health Care Workers (HSPs) stated that supportive supervision involved transfer of knowledge (18.8%), motivation (8.0%), performance feedback (23.2%) and sharing new development (18.8%). The majority of supervisees interviewed (83.9%) however perceived that supportive supervision will be helpful in building their capacity, motivating and improving their confidence. Rombo, where EGPAF has been providing support in clinical mentoring for a considerable period of time, Care and Treatment Clinic (CTC) - based HSPs reported that mentoring helped them acquire knowledge and build their skills and confidence to improve their clinical practice

Achievements in supportive supervision and mentoring:
Achievements reported by the HIV and AIDS leads in supportive supervision include timely reporting, improved supplies management, improved patient management and partners' adherence to national HIV guidelines. HSPs reported improvements in VCT services, filling of

supplies and report writing. In addition, HSPs from Rombo and Iringa reported improved clinical performance due to mentoring. It was also stated by the district mentors that clinical mentoring led to reduced referral of patients and facilitated the initiation of ART in children at lower level facilities.

Challenges in providing supportive supervision and mentoring:

Some of the challenges included:

- Lack of a standardized approach to supportive supervision and mentoring,
- Lack of adequate and reliable financial resources,
- Lack of guidelines on mentoring,
- Shortage of human, financial and time resources,
- Lack of technical skills and work overload among HSPs, and
- Vertical, uncoordinated intervention-specific supervisory activities

1.5.2 Key Recommendations:

The key recommendations included:

- Develop a national manual and tools on comprehensive supportive supervision and mentoring to guide implementation of supportive supervision and mentoring to cover all HIV and AIDS health services at all levels of the entire health care delivery system;
- Adopt effective comprehensive supportive supervision and mentoring approaches and establish supervisory and mentoring teams at national, regional and district levels;
- Develop a standardised national training package on supportive supervision and mentoring for HIV and AIDS health services;
- Institute a long-term capacity development programme for practicing supervisors and mentors and newly recruited HSPs through formal and on-the-job training. To facilitate this, there is a need for a standardised training package for mentors and supervisors;
- Ensure the sustainability of supervisory and mentoring activities by advocating for the activities to be planned (and budgeted for) at all levels of the health care delivery system. The two key ministries (PMORALG and MOHSW) should take the lead;
- Continually pursue innovative ways to address the HRH crisis;
- Put in place a quality improvement (QI) system in line with the national guidelines;
- Introduce an efficient and regular monitoring and evaluation system for supervision and mentoring activities; and
- Document and share good practices with various stakeholders at various forums (in- and out of the country).

NB: The full version of the Situational Analysis Report on Supportive Supervision and Mentoring in Tanzania is available at the NACP.

Chapter 2: Introduction to the Manual

2.1 Rationale for Comprehensive Supportive Supervision and Mentoring

For decades it was assumed that poor performance was simply due to lack of knowledge and skills. As a result, most interventions concentrated on training, which has had mixed and sometimes disappointing long-term results. An in-service training is expected not only to transfer new knowledge and skills but also to change behaviour of health service providers (HSPs) for application of the knowledge and skills at their work stations. However, this behaviour change doesn't come along with the training alone because other physical, social and systemic problems may be hindering the individual HSP from applying the knowledge and skills.

Therefore, supervision has an important role to identify and solve gaps and reinforce HSPs in application of and adherence to the service standard. The main challenge for supervision has been measuring its cost, time and performance efficiency and effectiveness for health service quality improvement. This challenge, however, is still at large. Too often supervisors lack skills and knowledge, useful tools, funds and transportation and are burdened with other administrative duties.

In the area of HIV and AIDS, rapid increase of patients in need of comprehensive HIV services in the early 2000s was the major driving force behind the re-focus of major global and local priorities. The UNGASS Declaration of Commitment that advocated and established targets for each member country for provision of HIV quality and comprehensive prevention, care, treatment and support services to all who need the services came into being in October 2001.

The MOHSW was not far behind the global agendas as the first National Care and Treatment Plan was operational by 2004 with a major focus on expanding HIV Care and Treatment services to meet the ever rising demand. Since then, many HSPs were trained in HIV and AIDS interventions such as HTC, PMTCT, Home-based Care, management of Opportunistic Infections (OIs), ART, Syndromic Management of Sexually Transmitted Infections and Reproductive Tract Infections (STIs/RTIs), laboratory tests for HIV diagnosis, monitoring patient on ART, management of tuberculosis (TB) and HIV co-infection. All these HIV and AIDS health services require to be integrated into ongoing health service delivery. HSPs have been asked to take on new and complex roles at a rapid pace while continuing to provide the comprehensive health care services to the populations they serve. Strengthening supportive supervision therefore is a critical part of human resource management for the delivery of quality health care services especially in HIV and AIDS.

In Tanzania, however, supervision on HIV and AIDS services has generally been erratic, vertical and unlinked. Supervision has been conducted by both government and implementing partners in uncoordinated manner using different supervision tools. Some interventions were left alone from supervision simply due to lack of fund. Supervision depends more on the availability of transport and other resources. Sometime, several supervisors visit a health facility within a short period of time, providing conflicting guidance.

This often leaves the facility staff confused and demoralized. Vertical supervision cannot meet all the requirements including specific technical and clinical needs of HSPs. On the other hand, technical/clinical problem solving in a specific intervention requires experienced practitioners and ample time. Supervisors have limited capacity to comprehensively cover both administrative and technical issues while mentoring is relatively an unpopular concept. Therefore, performance- and resource-related problems at the health facilities remain unsolved.

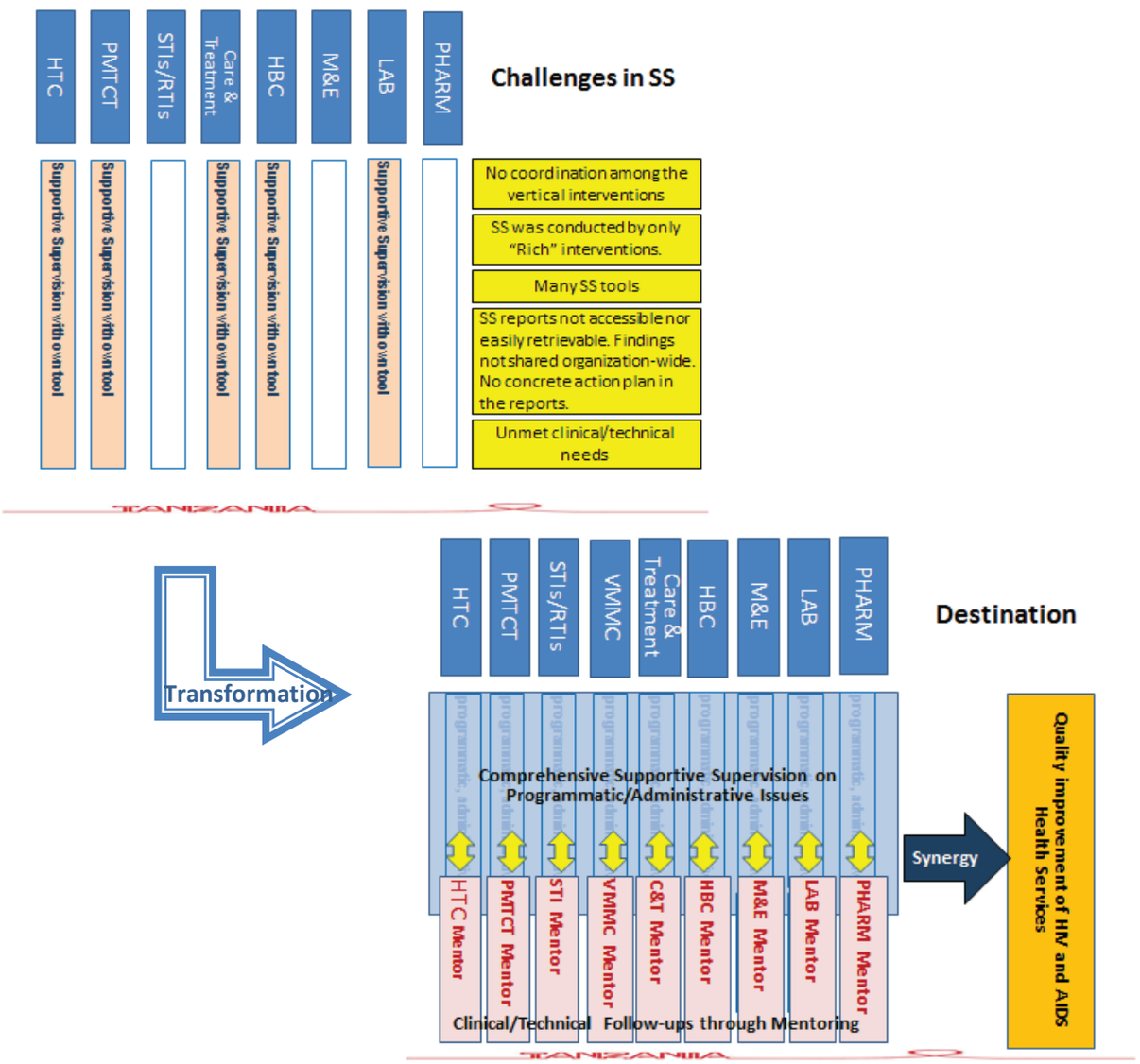

Figure 2. Destination of Comprehensive Supportive Supervision and Mentoring for HIV and AIDS Health Services

A change in supervision to comprehensive supportive supervision in combination with mentoring had become a critical need. Supportive supervision and mentoring are complementary activities necessary to build a continuum of care and support. Mentoring by experienced practitioners should be conducted based on the clinical and technical needs and demand driven rather than regular practice.

Recognizing the challenges and the need, the MOHSW through the NACP developed a Manual and Tools for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services in 2010 (MOHSW, 2010). Some new approaches in HIV prevention have been introduced to the country and some other shortfalls have been identified in the manual and tools since then. Therefore, this revision was made to cover those shortfalls.

2.2 Purpose of the Manual

The purpose of this manual is to standardize the approach to comprehensive supportive supervision and mentoring processes and activities in HIV and AIDS health services. This manual will complement the National Supportive Supervision Guidelines for Quality Health Care Services (MOHSW, 2008), the National Guidelines for Quality Improvement of HIV and AIDS Services (MOHSW, 2010) and the National Essential Health Sector HIV and AIDS Interventions Package (MOHSW, 2010), as well as intervention specific guidelines and standard operating procedures (SOPs). The contents of the manual is revised in accordance with the training package for comprehensive supportive supervision and mentoring developed in 2011 (MOHSW, 2011) as well as incorporating recent introduction of new approaches into the country.

2.3 Objectives

The objectives of this manual are to:

- Provide a standardized definition of supportive supervision and mentoring;
- Provide a rationale for a standardized approach to comprehensive supportive supervision and mentoring in Tanzania;
- Provide guidance on planning and implementation of comprehensive supportive supervision and mentoring for improving quality of HIV and AIDS health services; and
- Provide strategies for bringing about synergy between supportive supervision and mentoring.

2.4 Target Audience of the Manual

The target audience of this manual includes:

1) Programme managers, administrators from public and private sectors and partners who implement HIV and AIDS health services in Tanzania;
2) Supervisors and mentors who are responsible for HIV and AIDS health services at national, zonal, regional, council, health facility and community levels; and
3) Trainers who provide in-service and pre-service training to health care workers.

Chapter 3: Concept of Supportive Supervision and Mentoring

03

3.1 Overview of Supportive Supervision

Supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimizing the allocation of resources, promoting high standards, team work and better two-way communication (MARQUEZ & KEAN, 2002). Supportive supervision involves directing and supporting HSPs in order to enhance their skills, knowledge and abilities with the goal of improving health outcomes for the patients they manage. It is an ongoing relationship between HSPs and their supervisors.

Some of the characteristics of supportive supervision as described in the National Supportive Supervision Guidelines (MOHSW, 2010) include: 1) problem identification and solving to improve quality and meet client needs, 2) quality improvement and the attention shifts from individuals to teams and processes, 3) empowering health providers to monitor and improve their own performances, 4) external supervisor acting as a facilitator, trainer and coach, 5) participation of HSPs in supervising themselves and one another, 6) participatory decision making involving the whole team and 7) peer assessment, self-assessment and community input consideration.

3.2 Traditional Supervision vs. Supportive Supervision

Although the traditional approach to doing supervisory visits is effective to some extent, it also has several shortcomings. For example, the supervisors leaned more towards facility inspection rather than guidance for problem-solving to improve performance. Supportive supervision promotes sustainable and efficient programme management through interactive communication, as well as performance planning and monitoring. Table 1 below highlights some of the differences between traditional supervision and supportive supervision. A major trend in efforts to improve supervision has been to shift the focus of supervisors and supervisees away from simply inspecting facilities and gathering service statistics to concentrating on the performance and resolution of problems experienced by the HSPs, as well as to increase feedback from supervisors. There have been a lot of efforts to refocus supervision toward activities such as assessing compliance with quality standards, transferring knowledge and skills, identifying problems and developing action plans for improvement.

Table 1: Comparison of Traditional and Supportive Supervision (Adapted from Marquez and Kean, 2002)

Action	Traditional supervision	Supportive supervision
WHO performs supervision	External supervisors designated by the service delivery organization	External supervisors designated by the service delivery organization, staff from other facilities, health facility management team or colleagues from the same facility (internal supervision), community health committee, staff themselves through self-assessment
WHEN supervision happens	During periodic visits by external supervisors	Continuously: during routine work, team meetings, and visits by external supervisors
WHAT happens DURING supervision encounters	Inspection of facility, review of records and supplies, supervisor makes most of the decisions, reactive problem-solving by supervisor, little feedback or discussion of supervisor observations	Observation of performance and comparison to standards, provision of corrective and supportive feedback on performance, discussion with clients, provision of technical updates or guidelines, onsite training, use of data and client input to identify opportunities for improvement, joint problem solving, follow-up on previously identified problems
WHAT happens AFTER supervision encounters	No or irregular follow-up	Actions and decisions recorded, ongoing monitoring of weak areas and improvements, follow-up on prior visits and problems

3.3 Overview of Mentoring

Mentoring is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. Mentoring should be seen as part of the continuum of education required to create competent HSPs.

When expertise in a particular intervention is not found at the primary health facility level, an experienced practitioner in a hospital shall provide mentoring to less-experienced HSPs by responding to questions, reviewing clinical cases, providing feedback and assisting in case management. This mentoring occurs during site visits as well as via ongoing phone and e-mail correspondence. Mentoring relationships work best without directive approach to where both a mentor and a mentee learn from each other. It is a learning opportunity for both parties. It should be noted however that a mentor must be a practicing person who is more experienced with greater knowledge and skills, and who is willing to empower a junior or inexperienced HSP. Mentoring is critical to building successful national, zonal, regional and council networks of trained HSPs for continuum of HIV prevention, care and support in resource-constrained settings.

The WHO further lists the objectives of mentoring as:

- Supporting decentralized delivery of HIV care, antiretroviral therapy and prevention with high-quality care at all levels;
- Supporting the application of classroom learning to clinical care;
- Maintaining and progressively improving the quality of clinical care;
- Building the capacity of first-level care workers health centre staff) and second-level health care workers (district hospital staff) to manage unfamiliar or complicated cases such as antiretroviral therapy toxicity, immune reconstitution inflammatory syndrome, complicated HIV/TB cases, treatment of children or pregnant women or referring them when appropriate; and
- Improving the motivation of health care workers by providing effective technical support.

3.4 Relationship between Supportive Supervision and Mentoring

While mentoring and supportive supervision have several areas of overlap as depicted in Figure 3, each requires different skills and professional carrier and should be undertaken by different, but complementary teams. Whereas mentoring mostly targets individual practitioners or small groups, supportive supervision provides an excellent opportunity for follow-up training, to improve overall performance and solve other systemic problems that contribute to poor service delivery. Mentors need to be very experienced and practicing individuals while supportive supervisors can be trained management/programme staff.

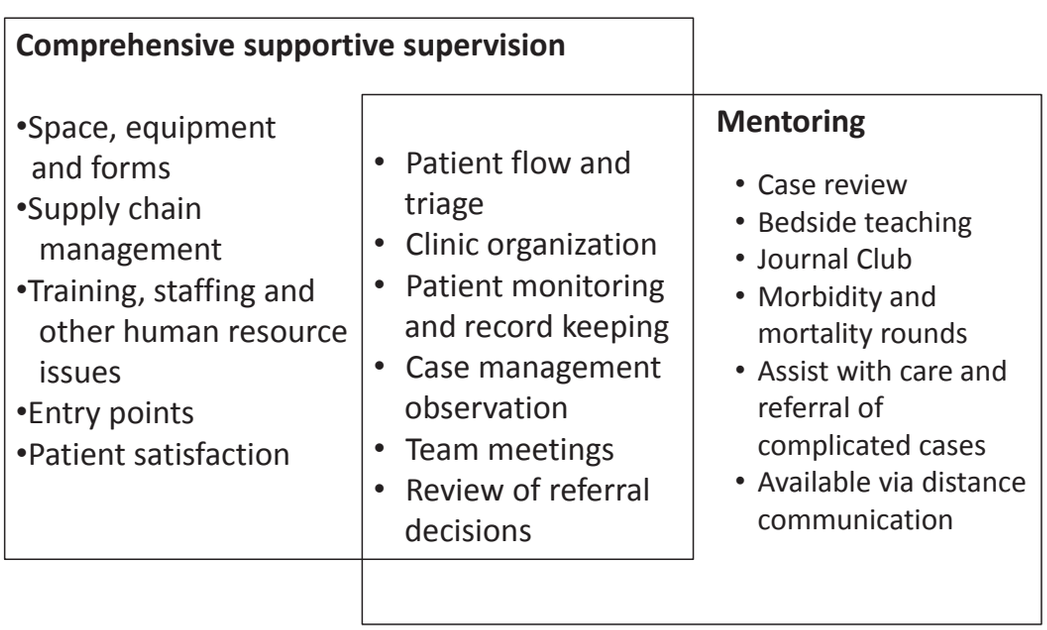

Figure 3: Relationship between Supportive Supervision and Mentoring
Adapted from: WHO Recommendations for Clinical Mentoring to Support Scale-Up of HIV Care, Antiretroviral Therapy and Prevention in Resource-Constrained Settings

At the clinic level, effective patient care requires that both mentors and supervisors monitor clinic activities such as patient flow and triage, clinic organization, patient monitoring, record-keeping, case management, team meetings, and review of referral decisions. While supportive supervision is a regular activity, mentoring is conducted based on technical/clinical needs. As such it is important for these two systems to work together to maximize the effectiveness of each and to avoid duplication of efforts. Table 2 below summarizes the differences and similarities between supportive supervision and mentoring.

Table 2: Differences and similarities between supportive supervision and mentoring

Supportive Supervision	Mentoring
• Is a regular activity • Focuses on a systemic and programmatic total improvement • Provides an opportunity for follow-up training to improve overall performance and solve other systemic problems that contribute to poor operations	• Is required when technical/clinical needs arise • Focuses on individual clinicians or small groups and their impact on productivity • Provides individuals with on-the-job skill training for a specific area of intervention as part of continuous education and learning for professional development
Required skills: • Comprehensive knowledge on health systems and HIV and AIDS interventions • Leadership, managing, coaching, negotiation, advocacy, facilitation and team building skills • Problem identification and solving • Information/data collection, analysis and interpretation	Required skills: • Rich technical/clinical knowledge and skills in a specific intervention • Coaching, negotiation and facilitation skills • Problem identification and solving • Information/data collection, analysis and interpretation

Chapter 4: Setting up a National Supportive Supervision System

In order to set up the national supportive supervision system, it is important to define attributes, competencies and training of supervisors as well as resources needed and items to be covered during supervision.

4.1 Attributes of a Supervisor

A supervisor should have the following attributes:

- Familiar with health care system;
- Familiar with the HIV and AIDS health services (interventions) to be provided at each level of health system as stipulated in the National Essential Health Sector HIV Interventions Package;
- Ability to address both administrative and programmatic issues and needs in HIV and AIDS health services;
- Committed, responsible and have strong interpersonal skills;
- Ability to train, motivate and support supervisees; and
- Flexible, respectful and hardworking attitude.

4.2 Core Competencies of a Supervisor

As per MOHSW National Supervision Guidelines, the supervisor should have attained the following competencies:

- Conceptual skills: ability to listen, probe and analyze situations, problems and formulate solutions;
- Sufficient knowledge about comprehensive HIV and AIDS health services and health system;
- Interpersonal communication skills;
- Ability to coach, train and convey information to others and learn from them;
- Sufficient knowledge of concept of quality improvement (QI) including supportive supervision and mentoring and the use of national guidelines and SOPs:
- Ability to collect, analyse, visualize, interpret and feedback information/data
- Deep understanding of the roles and responsibilities of both supervisors and mentors and align oneself with mentors; and
- Ability to provide and receive feedbacks after each visit and write reports.

4.3 Training of Supervisors

Since HSPs in managerial positions at national, regional, district and facility levels are supervisors by the nature of their positions, they require training in order to make them effective supervisors. Their training should be based on a standardized training curriculum which should cover the following topics:

- Basic concept of quality, quality improvement (QI) and quality assurance (QA);
- Purpose of conducting comprehensive supportive supervision;
- Supportive supervision process and key issues to be covered during supervision;
- Communication and coaching skills;

- Roles and responsibilities of both supervisors and mentors;
- Structure and functions of national comprehensive supportive supervision and mentoring;
- Practicum of comprehensive supportive supervision including the use of tools, forms, charts and registers used in the HIV and AIDS health services;
- Synergy between supportive supervision and mentoring; and
- Monitoring and evaluation.

4.4 Resources Needed for Comprehensive Supportive Supervision

The main resources required are:

- Trained supervisors
- Annual/quarterly/monthly supportive supervision plan (matrix)
- Reliable transport;
- Adequate time for preparation, travel, field visit, immediate feedback, reporting and follow-up activities;
- Budget for travelling allowances and fuel;
- Comprehensive supportive supervision tool and stationery;
- Previous supportive supervision report and mentoring reports if conducted
- Comprehensive supportive supervision manual and the latest HIV and AIDS intervention guidelines and SOPs;
- Monitoring and Evaluation tools;
- Support for supervision review meetings; and
- Any cost necessary for follow-up actions.

4.5 Issues/Areas to be covered during Supportive Supervision

Issues/areas to be covered differ depending on the level of supervision. The first list is targeting Regional and Council Health Management Teams (R/CHMTs), the second one is for Zonal Health Resource Centres (ZHRCs) and the third one is for health facilities.

4.5.1 Issues/Areas to be covered during Supportive Supervision to R/CHMTs:

- Coverage of HIV and AIDS health services in a given region or district
- Human resource adequacy, availability of trained HSPs and training needs
- Resource management for HIV and AIDS intervention activities, supportive supervision, mentoring and QI
- Implementation and documentation status of HIV and AIDS activities in line with the plan
- Coordination with implementing partners in joint planning, implementation, documentation and its sharing
- Referral system and linkages to care and support
- Availability and dissemination of latest policies, guidelines, SOPs, job aids , manuals and IEC materials
- Quality improvement initiatives

4.5.2 Issues/Areas to be covered during Supportive Supervision to ZHRCs:

- Incorporation of HIV and AIDS trainings and activities in their short, medium and long-term plans;
- Resource mobilization for successful implementation of planned activities;
- Coordination and implementation of HIV and AIDS trainings in the zone;
- Availability of and adherence to HIV and AIDS related policies, guidelines, SOPs and training materials;
- Supportive supervision conducted to training institutions in the zone; and
- Overall capacity (technical skills, financial and other resources) to support RHMTs, CHMTs and training institutions in their zones

04

4.5.3 Issues/Areas to be covered during Supportive Supervision of Health Facilities

4.5.3.1 Management and quality improvement

- Functionality of QI team and Medicine and Therapeutic Committee
- Data analysis, presentation, interpretation, use and dissemination
- Linkages between interventions

4.5.3.2 Prevention Services

Prevention of Mother to Child Transmission of HIV (PMTCT)

- Availability and utilization of the current PMTCT guidelines and SOPs
- Availability of reporting forms and registers
- Availability and correct use of HIV test kits
- Availability of PMTCT services at Reproductive and Child Health (RCH) clinics
- Coverage of pregnant women tested and given results including their partners
- Availability of efficacious regimen for HIV positive pregnant and lactating women and exposed babies
- Enrolment of all pregnant HIV positive women into ART
- Availability of efficacious regimen for HIV positive pregnant women and exposed babies
- Adequate equipment and supplies in labour ward
- Status of HIV positive pregnant women with CD4 and viral load test done
- Provision of Cotrimoxazole prophylaxis to HIV exposed babies
- Access to HIV Early Infant Diagnosis (DNA PCR) and transportation of Dried Blood Spot (DBS) samples
- Ability in WHO clinical staging for monitoring HIV positive pregnant women
- Data management and utilization
- Follow-up of HIV exposed babies
- Counselling support for infant feeding
- Male involvement in PMTCT services
- Availability of family planning services
- Availability and use of TB screening tool
- Availability and use of Syphilis rapid test kits
- Follow-up of lost to follow-up cases
- Space adequacy and privacy
- Availability of IEC materials

Management of STIs/RTIs

- Availability of the current STI/RTI guidelines and protocols/flow charts for management of STIs/RTIs
- Adequate number of staff trained in STI/RTI case management and youth-friendly services
- Provision of PITC services
- Availability of essential STI/RTI drugs (1st and 2nd line)
- Availability of penile and pelvic models and demonstration of how to use condoms
- Condom availability (both male and female)
- Contact tracing mechanism
- Referral and linkage with other interventions
- Availability and use of IEC materials
- Availability of essential equipment and commodities
- Availability of recording and reporting tools for STI/RTI services
- Data Management - recording, analysis, utilization, reporting and record keeping
- Availability of Syphilis rapid test kits
- Space adequacy and privacy
- Availability of IEC materials

Voluntary Medical Male Circumcision (VMMC)

- Availability and utilization of the current guidelines and SOPs
- Adequate number of staff trained
- Adequate site management
- Availability of reporting forms and registers
- Availability of medicine, commodities and equipment
- Service provision status
- Referral and linkage with other interventions
- STI screening
- Infection prevention control
- Space adequacy and privacy
- Data management and utilization
- Availability of IEC materials

4.5.3.3 Treatment, Care and Support Services

HIV Care and Treatment (C&T)

- Availability and utilization of current National Guidelines for the management of HIV and AIDS
- Adequate number of trained staff
- Availability and usage of reporting forms and registers
- Data management and its utilization
- Patient flow and triage
- CD4 testing to all pre-ART and ART patients for baseline and follow-up in every six months
- Adherence assessment of all ART patients at every visit
- All patients on ART return to clinic for follow-up within one month of starting ART

- Cotrimoxazole prophylaxis given to all eligible HIV patients
- Availability and utilization of TB Screening tool and provision of adequate laboratory tests
- Adequate TB infection control measures
- Provision of Isoniazid Preventive Therapy (IPT) to HIV clients who are free from active TB
- Availability of Post Exposure Prophylaxis (PEP) for HSPs and community
- Management of missed appointments and loss to follow up
- Magnitude of treatment adverse effects and treatment failure
- Availability of 2nd line regimen
- Availability of paediatric ART services
- Functionality of patient review team for switching ARV regimen
- Screen for unmet family planning demand and proper referral
- Adequate nutritional assessment and availability of therapeutic foods
- Referral and linkage with other interventions / health and social services
- Space adequacy and privacy
- Infection Prevention Control (IPC)

Collaborative TB and HIV

- Availability and utilization of current national policy, treatment guidelines, and SOPs
- Magnitude of TB/HIV burden
- Adequate number of staff trained
- Availability of HIV test kits
- Availability of anti-TB drug, Cotrimoxazole and Pyridoxine
- Status of HIV testing to TB patients
- Availability and use of national TB screening tool
- Status of TB screening among PLHIV
- Provision of Cotrimoxazole prophylaxis to TB/HIV co-infected patients
- Data management and utilization
- Availability of condoms and IEC materials
- Referral system and linkage with other interventions / health and social services
- TB Infection control measures

Community Based HIV and AIDS Services (used to be called Home Based Care) at facility level

- Availability of community volunteers and HSPs trained on and actively providing home based care services
- Availability and utilization of national guidelines, protocols and SOPs
- Management of C&T and PMTCT clients who have been lost to follow up
- Availability of equipment and commodities
- Referral and linkage with C&T, TB, Reproductive and Child Health (RCH) and Family Planning (FP), and social and legal services
- Availability and use of recording and reporting tools
- Data management and utilization
- Promotion of positive health, dignity and prevention (PHDP) services such as condoms, insecticide treated nets (ITN), safe water and male circumcision

- Promotion of male participation in caring for patients, accessing HIV test (couple or home counselling and testing) and PMTCT
- Identification of training needs
- Availability of IEC materials

Community Based HIV and AIDS Services at Community level

- Availability and utilization of current national guidelines, protocols and SOPs
- Availability of equipment and commodities
- Availability and use of recording and reporting tools
- Data management and utilization
- Provision of adherence and nutritional counselling, health education and support services to patients on ART including HIV positive pregnant and lactating women
- Referral system and linkage with C&T, TB, RCH and FP, and social and legal services
- Promotion of PHDP services such as condoms, ITN, safe water and male circumcision
- Promotion of male involvement in caring for patients, accessing HIV test (couple or home counselling and testing) and PMTCT
- Availability of IEC materials

4.5.3.4 Cross Cutting Services

HIV Testing and Counselling (HTC)

- Availability of the current HTC guidelines, SOPs, protocols (including QA protocols) and job aids
- Availability/status of HTC services (VCT, PITC and HBCT)
- Status and trend of testing and receiving HIV test results
- Status of testing and counselling to couples and under 18 years
- Adequate number of trained staff (VCT and PITC)
- Availability and use of recording and reporting tools
- Data management and utilization
- HTC QA measures in place
- Status of male involvement
- Referral and linkage with other interventions
- Space adequacy and privacy
- Infection prevention control
- Availability and use of HIV test kits
- Availability of male and female condoms, penile and pelvic models and demonstration of condom use
- TB screening to PLHIV
- Availability of IEC specific for HTC

Laboratory Services

- Trained laboratory staff availability
- Space adequacy and privacy
- Availability of current guidelines, manuals, SOPs and HIV testing algorithms
- Availability of CD4 count, haematology, biochemistry analysis and viral load tests
- Logistic management of laboratory supplies including HIV rapid test kits

- Maintenance of laboratory equipment and its documentation
- Infection prevention control

Pharmaceutical services

- Availability and adequacy of medicines and medical supplies related to HIV and AIDS services
- Storage condition of medicines
- Tracking system (including verification of expiry date before receiving supplies)
- Record keeping and inventory
- Reporting and ordering
- Availability of pharmaceutical service staff trained on ARVs/OIs logistics
- Rational use of medicines and pharmacovigilance documentation and reporting

Social and Behaviour Change Communication (SBCC)

- Availability and use of IEC materials
- IEC materials given to patients/clients
- Availability of current guidelines on Abstinence and Being Faithful (A&B)
- Availability and recording of a ledger book for stock and distribution management of IEC materials
- Display of IEC materials (as per 5S guidance)

Monitoring and Evaluation (M&E)

- Management of stock of the recording and reporting tools for each intervention
- Implementation status of data quality assurance exercise to improve correctness and completeness of recording and reporting -
- Timeliness of reporting from health facility to council, from council to region and from region to national
- Filing and storage of data/reports
- Level specific clarity on recording and reporting and roles and responsibilities
- Evidence of data analysis, visualization, interpretation, feedback and use
- Data flow from health facility to national level

NB: The list may be reviewed and updated as and when required and other interventions which are not covered in this manual shall be added.

Chapter 5: Structure and Function of the National Comprehensive Supportive Supervision System

This chapter describes the structure of the national comprehensive supportive supervision system and presents the functions of each of the structural levels at national, regional, district, health facility and community.

5.1 National Level

At the national level, a supportive supervision team for HIV and AIDS health services will be composed of 3-5 members including programme leads, partners and co-opted members trained in comprehensive supportive supervision.

The team will conduct supportive supervision at the regional level, targeting RHMTs, national and referral/special hospitals and ZHRCs. The visits shall be twice a year and each visit will take at least five working days. From time to time when it is required, the team may also visit a few selected lower level health facilities. Several teams shall be formed with trained supervisors to be able to provide the service across the country.

The team shall pay a courtesy call to the Assistant Administrative Secretary – Social Cluster formerly known as Regional Medical Officer (RMO) for briefing at the start of the visit and de-briefing at the end of the visit. At the RHMT level, the team reviews the action plan of the preceding supervision visit, progress on service coverage expansion, resource management, implementation of regional annual plans and its documentation, coordination of implementing partners and progress of Public Private Partnership (PPP). The team also reviews the reports of supportive supervision to CHMTs and the activities of the regional Quality Improvement (QI) team. An action plan shall then be developed with the RHMT members and share it in the debriefing session.

The team may also accompany the RHMT conducting supportive supervision to one or two selected districts for capacity building of the RHMT.

At national and referral/special hospitals, the team spends at least two days to review action plan of the previous supervision visit, provide supportive supervision to all HIV and AIDS health services and develop a renewed action plan. The focus shall be on infrastructure, equipment and forms, supply chain management, patient and provider satisfaction, training and staffing and other human resources issues,. The team also looks into patient flow and triage, clinic organization, patient monitoring, record-keeping and reporting, team meetings and challenges.

When the team visit a ZHRC, it shall be in looking at availability of National HIV and AIDS documents, their capacity and plan in supporting regions, districts and training institutions in the zone on HIV and AIDS-related trainings and capacity to identify their training needs. The team shall also look on capacity to conduct post-training assessment and check reports of supportive supervision to training institutions. Action plan of the previous visit shall be reviewed and a renewed action plan shall be developed at the end.

5.2 Regional Level

Supportive supervision at the regional level shall be conducted by RHMTs and implementing partners of the relevant region. They provide supportive supervision to the regional hospital and CHMTs every quarter. RHMTs are strongly encouraged to integrate the supervision of HIV and AIDS into their general supportive supervision in order to ensure sustainability in its implementation.

The RHMT shall conduct supportive supervision to the regional hospital for one to two days. They shall review action plan of the previous SS visit, provide supportive supervision to all HIV and AIDS health services, develop a renewed action plan and provide feedback on the next day. The focus shall be infrastructure, latest guidelines, equipment and forms, supply chain management, patient flow and triage and clinic or organization. Other areas include patient satisfaction, patient monitoring, record keeping and reporting, team meetings, linkages, financial, managerial, training and staffing and other human resource issues. At the end of the visit, the team shall develop a renewed action plan with the Regional Hospital Management Team.

At the district level, the team shall pay courtesy call to the District Executive Director (DED) for briefing on the mission of the visit. At a CHMT, the regional team shall review the action plan of the previous SS visit, progress on service coverage expansion, resource management, implementation of HIV and AIDS activities under the CCHP and its documentation, coordination of implementing partners and progress of Public Private Partnership (PPP). The team shall also review the reports of supportive supervision to health facilities and the activities of the council Quality Improvement (QI) team. A renewed action plan shall be developed with the RHMT members and shared in the debriefing session.

In addition to supervising a CHMT, the team may accompany the CHMT conducting supportive supervision to a few selected health facilities including the District Hospital for follow up and capacity building. The regional team is expected to spend about 3-4 days at district level. At the end of the visit, the team will provide a feedback to the CHMT and DED.

5.3 Council Level

A team of supportive supervision on HIV and AIDS health services at the council level consists of 2-4 members from CHMT core and co-opted members and implementing partners. The team targets health management teams of District Hospital and other health facilities under the CHMT (hospitals, health centres, dispensaries, pharmacies, and laboratory including ones that are run privately). CHMTs are strongly encouraged to integrate the supervision of HIV and AIDS into their general supportive supervision in order to ensure sustainability in its implementation.

The team shall pay a courtesy call to the in charge of the HFs for briefing on the mission of the visit. These visits shall be conducted on quarterly basis and spend a full day especially at the hospital level and at least half a day at health centre and dispensary level.

Since the implementation of many HIV and AIDS health services occurs at this level, the district hospital will require one to two days visit. The team shall start with review of the action plan of the previous visit, then provide supportive supervision to all HIV and AIDS health services, develop a renewed action plan and provide feedback to the hospital management team. The team will focus on infrastructure, supply chain management, equipment and supplies and human resource. The team shall also review the HIV and AIDS health service delivery in line with the current national guidelines and SOPs, patient flow and triage, clinic organization and team meetings. Other supervision areas shall include patient satisfaction, community linkages, patient monitoring and record-keeping and reporting and financial management.

5.4 Health Facility Level (Internal Supportive Supervision)

Supportive supervision at a health care facility shall be internal in nature and shall be conducted by the facility health management team members including the in-charge of the health facility and the QI team. This team is responsible for setting and monitoring quality standards of care and assuring that current guidelines and SOPs are disseminated and adhered to by the staff. The team is also responsible for supporting and motivating HSPs; training and recognition; forming and building teams; promoting 5S, in-house mentoring and team-based approaches to problem-solving; fostering trust and open communication; and collecting and using data for decision-making and improvement of services.

The team shall supervise all relevant units in the facility providing HIV and AIDS health services and all its HSPs. The team shall also discuss and promote the utilization of SOPs and look at infrastructure especially space, equipment and forms, supply chain management, patient monitoring, record-keeping and reporting and financial management. Other areas of interest are human resources, HIV service delivery based on guidelines, patient satisfaction, training needs as well as referral systems and community linkages. The team shall also supervise inventory, patient flow and triage, clinic organization and team meetings. The health facility in-charge shall bear the responsibility of ensuring that all action points agreed with council supervisors and mentors are implemented.

5.5 Supportive Supervision at the Community Level

The health facility in-charge and the relevant focal persons shall ensure that supportive supervision is provided at the community level. This will be conducted on a monthly basis or as need arises. The team shall pay a courtesy call to the Village Executive Officer during such a visit.

Community-based health care programmes and workers such as Village Health Workers (VHWs), Peer Educators, and HBC service providers shall be supervised. Supportive supervision shall be on SOPs, equipment and supplies, HIV service delivery based on guidelines, patient satisfaction, training needs, referral systems and community linkages.

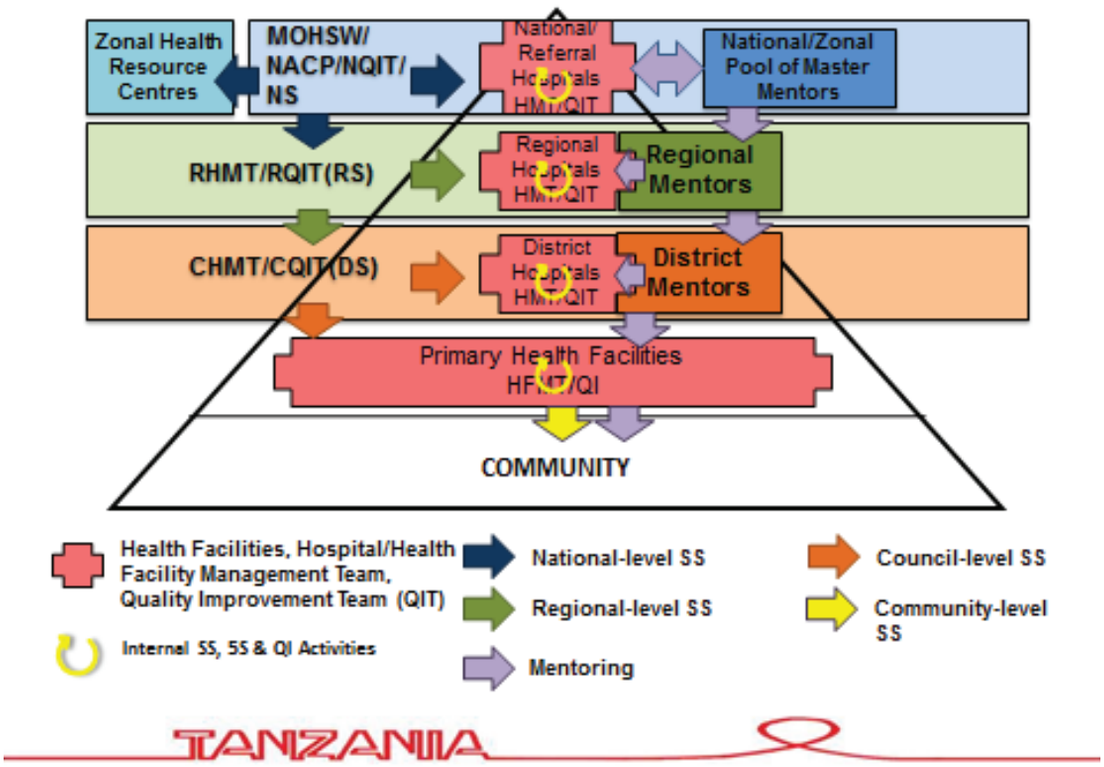

Figure 4: National Structure of Supportive Supervision and Mentoring

Chapter 6: Supportive Supervision Process

This chapter describes supportive supervision process which includes planning, getting started, conducting supportive supervision, giving feedback, wrap up and report writing. It also gives details on the roles and responsibilities of the supervisors at different stages as presented in Table 2.

Table 3: Stages and Specific Task in Conducting Supportive Supervision

Stages	Tasks to be Performed

Planning stage	• Identify sites/health facilities to be supervised and develop a route plan.
	• Inform the relevant authorities and supervisees on the dates, team composition, time, objectives of the visit and support needed at least one week before.
	• Take note of:
	  ○ All the available vital and M&E information about the region/council and health facilities to be supervised,
	  ○ All the strengths and challenges in delivering HIV and AIDS health services reported and action plan developed during the previous supportive supervision and mentoring visits
	• Communicate with supervisees if there is any supply needs so as to carry them on the day of supportive supervision.
	• Arrange logistics 2 weeks before
	• Organize a preparatory supervision team meeting the preceding day and have a common understanding on the region/council and health facilities to be supervised.

Getting started	• Pay a courtesy call to the relevant authority according to the level of supervision.
	  ○ Introduce yourself and the team
	  ○ Clarify objectives and
	  ○ Sites to be visited and schedule
	• Agree on a date and time for debriefing session.
	
	At the supervision site/ health facility:
	• Establish rapport - always start by greeting and introducing yourself and the rest of the team to the supervisees;
	• Tell the in-charge and supervisees the purpose of the visit;
	• Let the supervisees introduce themselves and listen to them in a relaxed manner but attentive and avoid interruption;
	• Explain the whole supportive supervision schedule e.g. supervisees to be met, time to be spent, feedback session etc.; and
	• Use communication skills to encourage active participation.

Conducting supportive supervision	• Show respect and patience throughout the supervisory visit. • Allow time for staff to complete any consultations underway and for any hand over. • Review the previous action points and status of implementation. • Discuss action points from the previous visit and assess the current status • Observe and gather information using the supervision tool. • Listen to their problems and challenges. • Address and follow up on problem areas. • Provide corrective and supportive feedback on performance. • In case a procedure is performed incorrectly, demonstrate the correct procedure and ask for return demonstration. • Update supervisees on new guidelines and information. • Give on-the-job training on new techniques and approaches if required. • Do not give unrealistic promises and be honest when you don't know or don't have answers. • Ask some clients about their satisfaction to the services provided
Immediate feedback	• Once you are done with supervision, find a conducive environment (with privacy) to give feedback. • Use positive feedback, when performance is good; and constructive feedback, when performance needs improvement. • Start with those areas they are doing well followed by those where there are challenges. • Focus on systems and processes, the performance or action and not on the person/individual. • Discuss action points from the previous visit which were not implemented and include them in the new action plan. • Outline areas needing improvement and guide them to come up with corrective actions and time line. Link the behaviour to programme goals e.g. "If we don't get the reports on time, the patient on treatment numbers will be out of date by the time we get them back. Then we won't be able to use the information to improve our patients' services." • Listen attentively with encouragement and open mind, believing that everyone has good contributions to make. Give a chance to the supervisees to respond. • Invite the supervisees to give you feedback and questions. You may ask: ○ How did the process go? ○ What things did you find helpful? ○ What are some things that you didn't like, or were not helpful to you? ○ Are there things you want help with which we did not address today?

	○ Are there any technical/clinical issues to be attended by a mentor?
Wrap up	During wrap up, the following points should be discussed/considered: • Share new information, such as guidelines and training opportunities; • Share some observations/findings made such as data recording and reporting; • Summarize the specific aspects that require change or improvement, discuss/review and agree on what needs to be done and how. • Identify areas of strengths including specific aspects of care going well and commend them appropriately. • Identify areas that need improvement/strengthening and agree on the action points using a joint problem solving approach; • Set aside adequate time for supervisees' questions; • Identify persons responsible among supervisees and timeline to each action point ; • Sort out and prioritize issues to be mentored with the supervisees • When ready to leave, thank the supervisees and others.
Report writing and follow up action	• Use the report writing format to document the visit including action plans. • Disseminate the report to the relevant levels including the R/CHMT and HFs. • Make follow-up of the action plan developed. • If there is any technical/clinical issues that need to be mentored, identify appropriate mentors and dispatch them to meet the needs.

Chapter 7: Setting up a National Mentoring System

In order to have a functional national mentoring system, it is important to define attributes, competencies and training of mentors as well as resources needed and items to be covered during mentoring.

7.1 Attributes of a Mentor

For effective mentorship, a mentor requires the following attributes:

- Has sufficient knowledge, skills and experience in a specific HIV and AIDS intervention/service area;
- Be approachable and accessible with good interpersonal communication skills;
- Be actively practicing/providing services in a specific HIV and AIDS intervention
- Be familiar with the country's health system, common illnesses, the context of the disease, likely patient reactions and outcomes and appropriate language;
- Be willing, committed and available to provide technical assistance to less experienced HSPs; and
- Could be a nurse, clinician, pharmacist, laboratory technologist or any other practitioner in a specific HIV intervention/service with the above mentioned attributes.

7.2 Competencies of a Mentor

07

The core competencies of the mentor can be divided into two major categories:

a) Mastery of technical knowledge and skills
b) Effective mentoring techniques and communication skills

7.2.1 Mastery of Technical Knowledge and Skills to Provide Quality of HIV Care:

- Working knowledge of a specific HIV and AIDS health service; and
- Ability to help mentees improve knowledge, skills and confidence to provide HIV and AIDS health service accurately, consistently and independently.

7.2.2 Effective Mentoring Techniques and Coaching Skills:

- Ability to utilize effective mentoring techniques and coaching skills to transfer or impart the mentor's knowledge/skills to the mentee;
- Ability to establish an effective learning environment as part of a mentoring visit;
- Effective communication skills to make the mentee and the patient to feel at ease and comfortable at each other;
- Ability to share with the mentee teaching tips or clinical management suggestions in the presence of mentee and patient;
- Ensure that communication flows appropriately in three directions between mentee-client, mentor-mentee, client-mentor; and
- Use a variety of mentoring techniques such as bedside teaching, demonstration and return demonstration and clinical case review/discussions at several avenues including grand rounds.

7.3 Training of Mentors

In order to ensure that mentors are well-prepared and familiar with their work, it is important to cover the following key components in training:

- Updates of quality, quality improvement (QI) and quality assurance (QA);
- Communication and coaching skills;
- Basic concepts of mentoring and supportive supervision;
- Roles and responsibilities of mentors;
- Mentoring process and methods;
- Structure and functions of national CSS&M
- Practicum of mentoring including the use of mentoring tools;
- Synergy between supportive supervision and mentoring; and
- Monitoring and evaluation.

7.4 Resources Needed for Implementing Mentoring

Mentorship recognizes the importance of capacity development, continuing education, adult learning, and support for HSPs and the long term sustainability and wellbeing of both the personnel and health care system. This initiative needs stakeholders to mobilize resources for its implementation. The resources needed are similar to supportive supervision and include:

- Reliable allocated transport (can be shared with supervision team);
- Adequate time for mentors' preparation, travel, field visit, immediate feedback, reporting and follow-up activities;
- Travelling allowances;
- Communication cost;
- Stationery;
- Tools for mentoring;
- Current guidelines on implementation of HIV and AIDS interventions;
- Monitoring and Evaluation tools;
- Communication support: radio call, airtime, landline, e-mail or internet access; and
- Support for mentoring review meetings.

7.5 Issues/Areas to be covered during Mentoring

The following HIV and AIDS health services areas will be covered by different mentors according to their specific area of expertise.

7.5.1 Prevention Services

Prevention of Mother to Child Transmission of HIV Services

- HIV education, testing and post-test counselling (including partner involvement and couple counselling)
- History taking and physical examination, including WHO clinical staging
- Information on testing family members

- Laboratory test including CD4 count
- STI screening and management
- TB Screening and management
- ARV prophylaxis or treatment
- Counselling on maternal and infant feeding, family planning and prevention
- Adherence counselling and assessment
- Appointment systems, tracking and tracing defaulters including linkages and referral to other supportive services
- Clinical management of HIV positive mothers and exposed babies
- Maternity (Labour and delivery), delivery practices, universal precautions and ARV prophylaxis to mothers and infants
- Early Infant Diagnosis – DBS collection and transportation
- Recording and reporting (completeness, correctness and timeliness)

Management of STIs and RTIs

- History taking and clinical examination
- Use of flow charts in making diagnosis and management of STIs/RTIs
- Initiation of HIV education, testing and counselling including risk assessment and reduction plan.
- Emphasize on four guiding principles: compliance, condom use, counselling and confidentiality
- Condom demonstration (male and female)
- Utilization of partner notification card and management of sexual partners
- Case recording in STI register
- Blood collection for Syphilis screening
- STI monthly reports for completeness, correctness and timeliness
- Management of rape cases
- Referral to and linkages with Care and Treatment, TB and RCH clinics and Community Based HIV and AIDS Services
- Infection prevention control measures

7.5.2 Treatment, Care and Support Services

HIV Care and Treatment Services

- Triage of patients
- Initial assessment of newly diagnosed HIV patient
- History taking and physical examination including WHO clinical staging and diagnosis
- Lab tests ordering and interpretation of their results for assessment/monitoring disease progression
- Prevention and management of opportunistic infections (OIs)
- Initiation of Cotrimoxazole prophylaxis
- Intensified TB diagnosis in HIV positive adults and children
- Initiation of IPT for prophylaxis of TB
- Management of HIV in infants and children including use of first and second line ARVs
- Management of HIV in adults and adolescents including use of first and second line ARVs
- ART adherence counselling and assessment

- Nutritional assessment and support
- Diagnosis of treatment failure based on immunological and clinical criteria
- Management of complications like immune reconstitution inflammatory syndrome, adverse effects of ARV
- Management of HIV in pregnant and lactating women
- Patient appointment systems, tracking and tracing defaulters including linkages and referral to other supportive services
- Communication skills for rapport building
- Recording and reporting (completeness, correctness and timeliness)
- Referrals to and linkages with other interventions

Collaborative TB/HIV Services

- Radiographic and laboratory tests performed and interpretation of their results
- Diagnosis of TB in adults and children in accordance with guidelines
- Screening for HIV and STI in TB patients and suspects
- Management of diagnosed TB/HIV co-infected patients (adults and children) including the newly diagnosed
- Adherence counselling for anti-TB, ARV and Cotrimoxazole treatment
- Linkage and referral mechanisms between TB clinic and CTC and other interventions
- TB infection control and universal precautions
- Patient education for HIV prevention
- Management of side effects of ART and anti TB drugs
- Recording and reporting (completeness, correctness and timeliness)

Community Based HIV and AIDS Services

- Communication skills for rapport building
- Assistance to ART and Pre-ART clients including HIV positive pregnant and lactating women in need of nutritional counselling and support, side effect of drugs and selection of adherence assistant
- Caring model process (Assessment, plan, implementation and evaluation)
- Disclosure to family members
- Access to prophylactic drugs
- Adherence counselling for ART and PMTCT clients
- Tracking of lost to follow-up clients
- Promotion of home-based HIV counselling and testing
- Infection prevention and control at home settings
- Promotion of positive health, dignity and prevention services such as condoms, insecticide treated nets (ITN), safe water and male circumcision
- Promotion of male participation in caring for patients, accessing HIV test (couple or home counselling and testing) and PMTCT
- Referral linkages and networking with other interventions
- Recording and reporting (completeness, correctness and timeliness)

7.5.3 Cross cutting Services

HIV Testing and Counselling Services

- Client/patient flow in VCT and PITC
- Communication skills for rapport building
- Pre-test counselling or information (counselling skills and contents)
- HIV testing procedure (explanation, consent, testing procedure and algorithm)
- Post-test counselling, disclosure counselling and partner notification
- Risk assessment and reduction plan
- Family or couple counselling for concordant and discordant results
- Guiding principles (3 Cs: Counselling, Consent, and confidentiality)
- Promotion of positive health, dignity and prevention
- TB screening for HIV positive clients
- Infection prevention measures
- Linkages and referral systems/mechanisms into care and treatment and other supportive services
- Paediatric HIV testing and counselling
- Universal precautions and safety at the site
- Recording and reporting (completeness, correctness and timeliness)

Laboratory Services

- Communication with respect for confidentiality and privacy
- Standard basic laboratory service
- Management of samples including sample transportation
- Diagnostic tests according to SOPs and QA protocol
- Laboratory equipment maintenance and documentation
- Universal precautions at the laboratory
- Recording and reporting (completeness, correctness and timeliness)
- Quality assurance measures

Pharmaceutical Services

- Communication skills for establishing therapeutic relationship
- Validation of prescription
- Dispensing with transfer of accurate information to patients
- Paediatric formulation
- Record keeping for dispensed items
- Adherence assessment and counselling
- Assessment of clinical signs of urgent medical problems
- Stock management with documentation
- Adverse drug reactions reporting
- Quantification

Monitoring and Evaluation

- Ordering of the tools use of routinely collected data to order stock of the forms
- Recording - understanding of each and every variable in the form/register

- Reporting – understanding of each indicator, numerator and denominator and how to count each from the register/form; how to compute for percentages
- Management of filled forms/registers-filing system and archiving data
- Data analysis, presentation, interpretation and utilization for service improvement, development of specific health intervention and other decision-making (e.g. estimates of drug requirements and supplies)
- Data Flow - rationale for timely reporting to the higher level
- Feedback - identified strengths, area if improvement and best practices and feed back to the mentees
- Database management – availability of computer-based database, hardware and software management, anti-virus management, internet connectivity, data entry, generation of reports and data backup

Chapter 8: Structure and Functions of the National Mentoring System

This chapter describes the structure of the national mentoring system. It also presents the functions of each of the structural levels at National, Regional, District, Health Facility and Community. Refer to the diagram (Figure 4: National Structure of Supportive Supervision and Mentoring) in the Chapter 5.

8.1 National/Zonal Level

At the national level, mentoring activities shall be done by a pool of national/zonal mentors identified, trained and coordinated by NACP. National/Zonal mentors shall be dispatched to regions by the NACP or the consultant hospitals in accordance with technical/clinical needs identified or reported. The NACP is responsible to make all the mentoring reports available at any time for sharing. The NACP shall provide coordination and guidance on mentoring to all zones and regions, disseminate the manual "A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services" to zones, regions and implementing partners, keep track of an inventory/database of experts who serve as national/zonal mentors in different HIV and AIDS health services of each zone/region, develop a monitoring and evaluation framework of mentoring activities, identify and empower mentors of mentors and ensure continuous mentor training. The NACP shall also organize synergy meetings involving mentors, supervisors and other key stakeholders to share information regarding mentoring activities undertaken and best practices. The national/zonal mentors' primary responsibility is to provide mentorship to regional hospitals and build capacity of regional mentors.

8.2 Regional Level

RHMTs shall coordinate and oversee the implementation of mentoring activities at the regional level. They shall disseminate the manual to districts, identify mentoring needs at the district level, create a team of regional mentors, coordinate mentoring activities, ensure documentation and communicate with NACP or consultant hospitals for facilitation/guidance and technical backstopping. Other responsibilities are to increase pool of regional mentors in the region. The regional mentors' primary responsibility is to provide in-house mentorship to the colleagues of the regional hospital and build capacity of district mentors. In addition, the RHMT shall develop activity calendar, organize meetings between supervisors and mentors for sharing information and follow-up of actions.

8.3 Council Level

CHMTs shall coordinate and oversee the implementation of mentoring activities at the district level. CHMTs shall identify mentoring needs at the HF level, select mentors; create and keep an inventory of district mentors, coordinate mentors and mentoring activities in the district, ensure documentation and facilitate information sharing, assess mentors' performance, follow up action plans and outcome of the mentoring and coordinate meetings between supervisors and mentors. CHMTs shall also be responsible for documenting and sharing good practices with other districts, regions, NACP and other

stakeholders including partners. District mentors target mentees in hospitals, health centres, dispensaries, FBOs, NGOs, parastatal organizations and other private owned health facilities.

8.4 Health Care Facility and Community Levels

Mentorship within the health facility is a cost effective and sustainable approach for quality improvement of the HIV/ AIDS services. Therefore, mentors are encouraged to provide mentorship to less-experienced staff providing HIV and AIDS health services at their own facilities. The health facility mentors shall also be responsible for mentoring community based care providers.

Chapter 9: Mentoring Process

This chapter describes the mentoring process, the frequency and the methods of conducting mentorship.

9.1 Process of Mentoring

Table 4 summarises the mentoring process.

Table 4: The Mentoring Process and Tasks Performed in Each Stage

Stage/Process	Tasks to be Performed
Pre-mentoring planning (Supervisor)	• Orient the health facility management and mentee to the upcoming mentorship initiative, which should cover the process and the expected outcome of mentorship. • Obtain permission from appropriate authorities. • Make necessary logistics • Plan and communicate with the mentee about the mentor's arrival date and time
Mentor's arrival at the HF	• Greet site authorities and staff. • If time allows, tour health facility to get a sense of how services are provided.
Establish a warm mentoring climate	• Introduce yourself to the mentee. • Establish a warm relationship with the mentee and health facility staff. • Make your mentee feel comfortable and at ease.
Arriving at a mentoring agreement with mentee	• Explain mentoring needs reported to you and major objectives of the mentoring visit. • Review the action plan of the previous mentoring visit and its implementation status with the mentee • Ask the mentee if there are any areas that the mentee especially wants to work on, or has had difficulty with. • Explain the mentoring process and how you like to mentor.
Assess mentee's performance with the mentoring tool	• Explain how you will assess the performance of mentee with the tool. • Use the tool as a guide to assess and record it as you go through the mentoring process.
Review records	• Review records e.g. registers or client file. Let the mentee summarize background information. • Identify a few issues to discuss with the mentee.
Establishing warm care environment for client/patient	• The mentee shall introduce the mentor to client/patient. Make the client/patient to feel comfortable, that both of you will attend the client/patient together.

Begin client/ patient care encounter with mentee	• The mentee shall start providing the service as he/she normally would. • The mentor's role at this point is to OBSERVE and ASSESS. Do not interrupt the mentee at this early stage. • Be attentive to what the mentee and patient are saying.
Identifying teaching moments	• Teaching moments occur when 1) you have identified something to contribute or teach during client/patient care encounter, and 2) the timing is appropriate to do so. • Contents that you may wish to contribute include: ○ Follow-up questions supplementing knowledge base; ○ Demonstrating a procedure; ○ Model communication skills; and ○ Suggest alternative management approach. • Timing for teaching moments: ○ Be mindful of WHEN and HOW you chip in; ○ Avoid long and extended discussion with the mentee in front of the client/patient; ○ Be mindful of what is and is not appropriate to discuss in front of the client/patient; and ○ Look for an opportunity to have a private conversation with the mentee, especially when providing constructive feedback to the mentee.
Client/Patient education and instruction	• Communicating instructions to client/patient is an opportunity to educate him/her and can be also an indirect way to educate the mentee.
Between clients/patients	• The private time you have with the mentee between clients/patients is an ideal time for targeted, focused teaching. • This can be an opportunity for the mentor to: ○ Reinforce key teaching points from earlier service provision session; and ○ Answer mentee's questions.
Next client/patient	• Process repeats • The mentee could feel more confident. • Allow the mentee to do most of the activities. • Review and assess the mentee's performance.
Post mentoring feedback session	• After all the clients/patients have been attended to, find a quiet and ideally private place for a feedback session with the mentee. • Ask the mentee: "how did the session go for you?" "What did you like?" and "what did you learn?" • Provide feedback to the mentee with the mentoring tool recorded, utilizing principles of providing effective feedback: ○ Start with positive, encouraging feedback. (things that you observed the mentee doing well); and ○ Then, identify areas you feel the mentee should work on. Be specific and concrete. ○ Conclude feedback with encouraging remarks; restate

	positive things that the mentee is doing. Encourage the mentee to keep working on self-improvement. • Ask the mentee to give you feedback. Examples of how to do this include asking the following questions: ○ How did the mentoring session go for you? ○ What things did you especially like? What was particularly useful for you? ○ What are some things that you didn't like, or was not as helpful to you? ○ Are there issues that we did not cover today? Are there things you want help with which we did not address today?
Planning the way forward	• At the end of the feedback session, make a plan with the mentee about next steps for continued professional growth. Agree on things the mentee will: ○ Work on after this mentoring session by when; and ○ Try to teach or support on a future mentoring visit. • Identify a means of communication between you and the mentee and invite mentee to call you with any questions that may come up between mentoring visits • Identify other ways that you can support the mentee between mentoring visits ○ Does the mentee need job aids? Were there questions/issues that came up today which the mentor did not have the answer to? Identify issues or questions that the mentor will look up (from other colleagues, senior mentors, internet, etc). Identify how the mentor will share what she/he learns with the mentee. ○ Plan the next mentoring session: When? ○ Prioritizing the issues for the next mentoring session
Documentation	• Document the mentee's performance utilizing the mentoring tool. This allows mentors to track mentee's improvement in specific areas. • Document all mentoring activities done using the mentoring reporting format: who was mentored, what was mentored, what methodologies were used, number of clients/patients seen together, what issues have been solved and what were unsolved and what the mentee needs to do with timeline. This will be an action plan for the mentee as well as a reminder to yourself to look for ways to introduce topics that have not yet come up for the next visit.

9.2 Duration and Frequency

Mentors shall conduct initial visit to health facilities in order to establish the needs and demands. Mentoring needs at the health facility will likely diminish in terms and duration as the health facility staff gradually gains experience and acquire skills. However, mentoring

shall be continued for as long as it is required. Remember that mentoring is an ongoing knowledge and skill transfer from mentor to mentee.

Mentors initially need to spend at least two days at the hospital level and one day at lower level health facility and mentor intensively, then the staff needs time to practice and implement. Mentoring leads to capacity building of health facility staff, and should be reflected in improved service delivery and improved outcomes.

It is expected that a health facility shall eventually 'mature' and be capable of delivering quality services independently. This is referred to facility graduation/maturity. Site maturity is measured by health staff clinical competencies and quality service provision. In the first few months, a facility needs to be intensively mentored and then in the subsequent few months this can be decreased both in frequency of visits and number of days that the mentor stays at the facility and eventually can be based on demand by the facility needs as per agreement between the mentee and the mentor. With time, the mentees shall become mentors themselves and can mentor other site staff and may be capacitated to mentor lower level staff.

9.3 Mentoring Methodologies

There are guiding principles and concrete techniques that can help a prospective mentor to begin mastering the skills of mentoring. Some of these methods are presented below:

9.3.1 Identification of a Teaching Moment

A "teaching moment" is an opportunity that comes up for a mentor to share insights, knowledge or skills with a mentee. However, it requires proper timing without interrupting a client/patient as the mentor interacts with the mentee. Identification of technical/clinical or knowledge gaps needs to be properly undertaken as it forms the basis and focus for mentoring. Here below are some tips for identifying the gaps for potential teaching:

During file review before patient encounter: As the mentor reviews a patient file with the mentee before the patient encounter, the mentor shall be clear what needs to be done based on the file review (examples: repeat CD4 count? assessment of medication toxicity? follow-up issues from previous visit?) Ask the mentee what she/he thinks are the priority issues to address today. A difference of opinion, or something which the mentee forgot or has overlooked, is an opportunity for a teaching moment.

During initial client/patient encounter: Observe how the mentee interacts with the client/patient. If the mentor has suggestions for improving the establishment of a warm client/patient care environment, the mentor can model how this is done. Modelling effective care behaviour is a powerful way to teach.

During history-gathering: Listen closely to what questions the mentee is asking of the client/patient. If there is something that the mentee overlooks which the mentor feels is important, this can be a teaching moment.

During physical examination: Mentors can demonstrate how to perform a physical examination, and how to utilize its findings to assist with clinical management decisions.

During formulation of management plan: Mentors can help mentees to formulate an optimal management plan. This is an opportunity for mentor and mentee to discuss the case.

During client/patient instructions and education: Mentors can model how to communicate client/patient instructions. This is an opportunity to educate the client/patient, but also a chance to educate the mentee discreetly.

9.3.2 Bedside Teaching

Bedside teaching is a powerful and effective means of teaching. It is especially useful for:

- Demonstrating physical findings and physical manifestation of various disease processes;
- Modelling compassionate patient care and effective communication skills;
- Combining history, physical examination, and laboratory/radiographic/other data in clinical decision-making and formulating a treatment plan (with patient participation and input); and
- Providing an opportunity for mentees to practice physical examination or procedural skills under the supervision/guidance of the mentor.

9.3.3 One-on-One Case Management Observation

This refers to the process of observing a mentee as she/he provides health services. The mentor provides guidance and shares his/her experience with the mentee. Most of the mentoring that occurs involves one-on-one observation.

9.3.4 Review of Patient Monitoring Data

09

Providing care for any chronic disease involves careful monitoring to ensure treatment efficacy, and to identify treatment-associated toxicities and side effects. In HIV care, some of the monitoring data to pay close attention to include:

- CD4 count within one month of enrolment, and every 6 months;
- Vital sign trends, especially weight (note: this is especially important in children!);
- Growth chart and developmental milestones in children;
- Baseline investigation;
- Screening for tuberculosis; and
- Safety monitoring e.g. Anaemia for patients on Zidovudine (AZT) and rash as well as hepatotoxicity for patients on Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI).

9.3.5 Documentation Review

Careful documentation in recording tools is essential for the successful operation of HIV and AIDS health services. Therefore, assisting mentees in developing good documentation practices can be a significant contribution a mentor can make to the clinical operations at a

site. Though this task falls in the overlap between mentoring and supportive supervision, mentors have an opportunity to observe mentees in actual clinical practice, and can make suggestions regarding documentation in real time. A good way to do this is through modelling, through which a mentor can show how to chart in a thorough yet also time efficient manner.

9.3.6 Clinical Case Discussion

Clinical case discussion refers to teaching that is based on a clinical case, rather than a lecture based on a certain clinical case. This is a very powerful way to teach clinical decision-making skills, and promote active discussion among participants.

Case discussions are especially vivid and memorable if they are based on an actual patient who was seen by both mentor and mentee. Other clinical staff at the mentoring site can also attend a clinical case discussion, even if they did not see the patient in question.

Clinical case discussions are best conducted using a blackboard, flip chart or pencil and paper. The mentor should think of her/himself not as a lecturer, but as a facilitator of discussion. The mentor/facilitator can and should pause frequently to ask the audience questions like "What else could you have asked the patient?" "What physical findings would you look for?" "What tests would you want to order?" "What do you think could be the problem?"

Begin a clinical case discussion with a brief case summary. It is often helpful to ask the mentee to summarize the case. Information covered in the case summary should include:

- Basic information about patient such as age, sex, CD4 count, major co-morbidities, etc.;
- Main complaint;
- History (pertinent positives, negatives);
- Vital signs;
- Physical examination findings (pertinent);
- Laboratory and radiographic findings;
- Generating a problem list;
- Issues identified during assessment and discussion for each problem;
- Differential diagnoses and diagnostic approach; and
- Management plan with inputs from members of the healthcare team.

9.3.7 Clinical Team Meetings

Clinical team meetings are opportunities to bring together all members of a clinical site, to discuss issues relating to patient care, promote continuous quality improvement at the health facility, and for staff to provide support for each other. The spirit of a clinical team meeting is to foster exchange of ideas and perspectives among different cadres of the healthcare team.

Clinical team meetings can serve as a forum to:

- Share what is going well in the clinic among various clinical team members;
- Share what is not going well and brainstorm on causes and ways to improve the

problem area with input from members of the team;

- Provide clinical updates that are important for all staff;
- Provide support for each other, particularly on the psychological burden of providing care for patients (including children) in difficult situations and encountering deaths of patients. This can help to prevent burnout among healthcare providers; and
- Promote continuous quality improvement at the health facility.

09

Chapter 10: Synergy between Supportive Supervision and Mentoring and Information Sharing

As explained in the preceding chapters, supportive supervision and mentoring are conducted by different teams though they are complementary and synergistic. This chapter describes the mechanisms of bringing about synergy between the two at national, regional, district, and health facility levels. "Synergy" is defined as the increased effectiveness that results when two or more people work together. In other words, it is "the effect whereby one plus one can result into more than two." The term synergy refers to the process of carrying out the two processes of supportive supervision and mentoring to the same group or groups of HSPs for achieving more substantive added effect and or impact on performance outputs/outcomes for overall quality improvement. In order to create synergy of the two, the following mechanism is proposed.

10.1 Synergy between Supportive Supervision and Mentoring

10.1.1 National Level

At the national level, supervisors, partners, mentors, and the national QI team are the key players creating synergy between supportive supervision and mentoring. Although supportive supervision and mentoring activities will be carried out at different times in a year, the teams should meet at least twice a year. At NACP the mentoring reports shall be tabled during the technical staff meetings. The national sub-committee meetings should also discuss supportive supervision and mentoring outcomes as a standing agenda item. The same agenda should also be discussed during the biannual MOHSW stakeholders' coordination forum.

Issues for discussion may include:

- Key findings during comprehensive supportive supervision;
- Mentoring activities conducted and their outcome;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Actions recommended to be undertaken at the national level to improve service delivery/patient care; and
- Monitoring and evaluation framework and its operational plan

10.1.2 Regional Level

Similarly at the regional level, RHMT, Regional AIDS Control Coordinator (RACC) and other co-opted members, regional supervisors, zonal and regional mentors, regional QI team and partners will be the key players to bring synergy between supportive supervision and mentoring activities. They will also implement the monitoring and evaluation framework for supportive supervision and mentoring. At this level, the teams will meet on a quarterly basis or may use biannual primary healthcare meetings, regional hospital boards and other existing regional health related meetings to discuss the following issues:

- Key findings from comprehensive supportive supervision;

- Mentoring activities conducted and their outcome;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Actions recommended to be undertaken at the regional level to improve service delivery/patient care;
- Action plans developed with supervisors and mentors; and
- Plans for monitoring and evaluation.

The RHMT meetings will be used to discuss the outcome of supportive supervision and mentoring visits. The Regional Commissioner and the RAS shall be involved in the meetings when political decision making is necessary.

10.1.3 Council Level

Synergy at the council level may be similar to that of the regional level. The key players at this level are the CHMT, District AIDS Control Coordinator (DACC) and other co-opted members, district supervisors and regional and district mentors, council QI team and partners. They shall meet on a monthly basis using existing forums like CHMT meetings, hospital governing committee meetings, council health service board meetings, and the standing committee on HIV and AIDS. These meetings shall be chaired by the DMO with the DACC being a secretary. Issues for discussion will be as follows:

- Key findings from comprehensive supportive supervision;
- Mentoring activities conducted and their outcome;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Actions recommended to be undertaken at the council level to improve service delivery/patient care;
- Action plans developed with supervisors and mentors; and
- Plans for monitoring and evaluation.

The decisions from the synergy meetings shall be shared with the District Commissioner (DC) and the DED.

10.1.4 Health Facility Level

At the facility level, the key players include the facility in-charge, health facility management team, the facility QI team and in-house mentors. Synergy meeting begins with immediate feedback from external supervisors or mentors to the key players. The key players will also meet during health facility governing committees to discuss issues identified through supportive supervision and mentoring, take appropriate actions and make follow-ups of the actions. The teams meet on a monthly basis to discuss:

- Key findings which arise during supportive supervision and mentoring;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Further action recommended to improve service delivery/patient care;
- Action plans developed with supervisors and mentors.

10.2 Documentation and Information Sharing of Comprehensive Supportive Supervision and Mentoring

10.2.1. Health Facility Level

Internal supportive supervision and in-house mentoring activities shall be documented as much as possible, so that the issues identified and actions planned through those activities shall be discussed with a reference during meetings of the health facility governing committees on a monthly basis and also be shared with external stakeholders. All critical issues identified through those activities shall be urgently discussed and reported to the DMO through DACC. The documents shall be appropriately filed for easy reference.

After an external supervision or a mentoring is conducted, it shall be documented and the report with an action plan shall be shared with the health facility in-charge, facility QI team, site supervisors for their follow-up of the actions at the facility level. The original copy shall be appropriately filed for reference. All the documents shall be accessible and easily retrievable to internal and external supervisors for their follow-up actions.

10.2.2. Council Level

All regular supportive supervision and needs-based mentoring visits shall be documented using the standard tools. Summary reports with concrete action plan shall be submitted to the DMO immediately after the visit and shared with the relevant CHMT members, the Council QI Team, district mentors and implementing partners through existing meeting mechanisms. All technical issues that need follow-up actions by mentors need to be discussed at the council level. Critical issues that need urgent regional or national attention and follow-up action shall be discussed within CHMT and reported to the RMO and the NACP as soon as possible for further actions. Those are red-flag issues that include stock-outs of ARVs or HIV test kits or reagent, shortage of registers, broken refrigerator and laboratory machines. All important administrative issues shall also be shared with the DED for consultation and follow-up action. The original reports shall be appropriately filed in folders by health facilities and kept on a shelf for easy reference. CHMTs shall have a central filling system whereby all supportive supervision and mentoring reports and meeting minutes are accessible and retrievable by all CHMT and co-opted members and implementing partners at the council level.

10.2.3. Region Level

All regular supportive supervision and needs-based mentoring visits shall be documented using the standard tools. Reports with concrete action plans shall be submitted to the RMO through RACC immediately after the visits and shared with the relevant RHMT members, the Regional QI Team, regional mentors and implementing partners through existing meeting mechanisms on a monthly basis. Technical issues that require mentorship from consultant hospitals need to be consulted with the consultant hospital management as soon as possible. Technical issues that need follow-up actions by regional mentors need to be discussed at the regional level. Very critical issues identified through those activities, which need urgent national attention (red flag issues), shall be discussed and reported to the NACP as soon as

possible. Administrative issues shall be also shared with the RAS for consultation and his/her follow-up action. The original reports shall be appropriately filed in folders by councils for easy reference. RHMTs shall have a central filling system whereby all supportive supervision and mentoring reports and meeting minutes are accessible and retrievable by all RHMT and co-opted members and implementing partners at the council level.

10.2.4. National Level

All regular supportive supervision and needs-based mentoring visits shall be documented using the standard tools. Reports with concrete action plans shall be submitted to the PM of the NACP immediately after the visits and shared with the National QI Team, relevant NACP technical staff, national mentors and implementing partners through existing meeting mechanisms. Very critical issues (administrative, logistical and technical) reported, which need urgent national attention, shall be discussed as soon as possible. Technical or logistical issues may need to be reported to the relevant directors or departments of the MOHSW for their actions depending on the magnitude and urgency of the issue. The original reports shall be appropriately filed in region folders for easy reference. The NACP shall have a central filling system whereby all supportive supervision and mentoring reports and meeting minutes are accessible and retrievable by all NACP staff and implementing partners at the national level.

Chapter 11: Monitoring and Evaluation of Comprehensive Supportive Supervision and Mentoring System

Comprehensive supportive supervision, mentoring and quality improvement are different activities but closely related and complementary functions all with the overarching aim of expanding and improving clinical services, especially at the Primary Health Care (PHC) HF level. Yet these are not stand-alone functions. For example, the implementation and evaluation of a mentoring programme requires close coordination with the supportive supervision team. Clinical and clinical systems gaps identified by supervisors and mentors (from direct observation of actual clinical practice, as opposed to deduce from chart reviews) can be fed back to the supportive supervision and QI teams for ongoing support and strengthening. Therefore monitoring and evaluation of supportive supervision and mentoring activities should occur at all levels by the national programme managers and coordinators, RHMTs and CHMTs as well as implementing partners.

Activities shall include:

- Baseline data/information collection;
- Assessment of availability, accessibility and retreivability of supportive supervision and mentoring reports
- Review of reports written by supervisors/mentors (required format, contents and comprehensiveness);
- Assessment of implementation status of action plans developed during supportive supervision and mentoring;
- Assessment of problems solved or services improved through supervision or mentoring
- Feedback from supervisees and mentees on supervisors and mentors' performance;
- Availability of minutes of meetings whereby issues identified through supervision or mentoring and their solutions were discussed;
- Use of comprehensive supportive supervision tools by supervisors and mentoring tools by mentors;
- Periodical assessment on the performance of supervisors and mentors; and
- Assessment of changes in HSPs' performance, utilization of services, client exit interview, observation of clinical practice, stocks of drugs and supplies, timely and accurate reporting and data utilisation.

References and Resources

ASPIRE/I-TECH. (2007) *Clinical Mentoring Concept Paper*. Unpublished

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. (2009) *Health Sector Strategic Plan III (July 2009 - June 2015)*. Dar es Salaam: MOHSW.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2008) *Health Sector HIV and AIDS Strategic Plan II (2008 - 2012)*. Dar es Salaam: NACP

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2013) *Health Sector HIV and AIDS Strategic Plan III (2013 - 2017)*. Dar es Salaam: NACP.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2014) *HIV/AIDS/STI Surveillance Report, Report No. 23*. Dar es Salaam: NACP.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2010) *National Essential Health Sector HIV and AIDS Intervention Package*. Dar es Salaam: NACP.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2010) *National Guidelines for Quality Improvement of HIV and AIDS Services*. Dar es Salaam: NACP.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. (2010) *National Supportive Supervision Guidelines for Quality Health Care Services*. Dar es Salaam: MOHSW.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2011) *Participant's Manual for Training on Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services.* Dar es Salaam: NACP.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. (2007) *Primary Health Services Development Programme (2007-2017)*. Dar es Salaam: MOHSW.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. (2011) *Quality Improvement Framework in Health Care.* Dar es Salaam: MOHSW.

TANZANIA. MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2009) *Situational Analysis Report on Supportive Supervision and Mentoring In Tanzania* (Unpublished).

TANZANIA. PRIME MINISTER'S OFFICE. (2013) *Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14-2017/18)*. Dar es Salaam: PMO.

TANZANIA. TANZANIA COMMISSION FOR AIDS, ZANZIBAR AIDS COMMISSION, NATIONAL BUREAU OF STATISTICS, OFFICE OF CHIEF GOVERNMENT STATISTICIAN, ICF INTERNATIONAL. (2013) *Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12*. Dar es Salaam: TACAIDS, ZAC, NBS, OCGS and ICF International.

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS. (2013) *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*. Geneva: UNAIDS.

MARQUEZ, L. and KEAN, L. (2002) Making Supervision Supportive and Sustainable: New Approaches to Old Problems. *Maximizing Access and Quality Paper*. No.4. Washington DC: USAID.

ROHDE, J. (2006) , Supportive Supervision to Improve Integrated Primary Health Care. *Occasional Papers.* No. 2. Massachusetts: Management Science for Health.

WORLD HEALTH ORGANIZATION. (2006) *WHO recommendations for mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings*. Geneva: WHO.

Annex: Roles and Responsibilities of the Regional Health Management Team (RHMT)

The RHMT is charged with the responsibility of overseeing the management of health services in a region. It is the team that advises the Regional Secretariat on matters related to ensuring improvement and maintenance of the health status of the population within the region through advice on the overall planning, implementation, delivery, monitoring and evaluation of quality health care within the region. The team is there to ensure that health related planning and interventions are therefore conducted in an integrated and holistic manner to involve all stakeholders and resources within the region (MOHSW 2008).

The roles and responsibilities of the RHMT are summarized below:

- Develop and execute 5 year strategic plan for RHMT, annual regional plans and strategies for RHMT
- Advise the Regional Secretariat on promoting and improving health related interventions across the region in order to improve and sustain the health status of the population within the region.
- Advise and provide technical backstopping to the Council Health Management Teams (CHMT) in their roles and responsibilities to plan and deliver quality health care services within their areas of jurisdiction
  - Technical back stopping for CHMTs for planning and reporting.
  - Support CHMTs to develop health centre and dispensaries plans
    - Advice on construction and rehabilitation of health facilities
    - Assess the distribution of health facilities within the councils in order to avoid duplications and promote use of existing FBO facilities
    - Monitor the distribution of and construction of additional health facilities within the councils to ensure equity of access and efficient use of available resources which includes existing health facilities
    - Monitor the staffing and equipping of all health facilities
  - Support CHMTs on financial and material resource management
  - Supportive supervision of the CHMT for the implementation of their CCHP
  - Review, analyse and comment CCHP and RRHP and give feedbacks to the Councils as well as to the Central level.
  - Facilitate the identification of training needs of Council health staff
  - Technical and clinical supervision of district (incl. designated) hospitals
  - Monitor the equitable distribution of medicines, medical supplies and equipment among the councils
  - Support CHMTs in managing health financing options that ensure sustainability and equity in health services provision (NHIF, CHF, exemption & waiver, use of funds collected at health facilities level)
- Advise Local Government Authorities (LGAs)directly and provide technical backstopping to the CHMTs on the correct and timely implementation of national policies, guidelines, and standards for both public and private health service providers within the LGAs
- Monitor advice and ensure that delivery of quality health care services is conducted within the frameworks of accessibility, affordability, equity and gender mainstreaming within all LGAs.
- Provide the necessary input requirements for effective planning and delivery of health services such as accurate data, new information and capacity development of CHMT

members and all Health service providers in public and private facilities

The RHMT shall comprise of technically qualified and sufficiently experienced team members, who will, on a day to day basis ensure that they operate as a cohesive unit with clear and unambiguous roles and responsibilities towards a common vision and mission for their region. They will operate towards meeting the overall targets of their joint annual regional health plan and budget in supporting LGAs to deliver quality health services and advising the Regional Secretariat on all health matters pertaining to the health status of the region's population and health services delivered.

The health and health related services include all those services delivered by public and private providers in all mobile centres, dispensaries, health centres and hospitals. Their responsibility extends to include NGOs, CBOs, pharmacies and drug sellers, maternity and nursing homes, radiological, laboratory and dental services.

This level of operation is the extension of functions of Ministry of Health and Social Welfare (MOHSW) and Prime Minister's Office-Regional Administration and Local Government (PMO-RALG).

1. Develop and operationalise RHMT plans and strategies annually from the 5 year strategic plan
2. Disseminate and support the translation of the policies, strategies and guidelines of the MOHSW / PMO-RALG by CHMTs
3. Support an appropriate environment for private sector development
    - Make sure that the Voluntary Agencies and other private sector providers are registered according to the procedures
    - Resolve any dispute or misunderstanding that arises between CHMTs and the private health service providers
    - Advocate for PPP and organize PPP meetings
4. Coordinate services in the Region
    - Advise for equitable distribution of all resources (NGO, vertical initiatives, and others) between the councils.
5. Support Human resource management
    - Strengthen HRH management
    - Support LGAs to develop innovative and creative retention and incentive schemes for the staff
    - Identify and collate LGAs and Regional Referral Hospital training needs, use them in planning, and submit to zonal training centres and other relevant authorities
    - Conduct Monitoring and evaluation, Collect and compilation of data from the councils
    - Analyse data collected
    - Report and feed back to councils and central level
    - Conduct operational research
6. Ensure the quality of services at all health and social welfare facilities.
7. Facilitate emergency and disaster preparedness and response
    - Facilitate the establishment of Council Emergency and Disaster Preparedness Response Unit
    - Assist the councils in the planning and logistic

8. Support and backstop Regional Referral Hospital
    - Support Regional Hospital to develop the hospital plan
    - Mobilize resources to provide technical back stopping for the management and clinical services
    - Facilitate capacity development in interpretation of policies, guidelines.
    - Support quality improvement of the hospital services
    - Conduct clinical and managerial supervision of the Regional Referral Hospital.
9. Instituting network system
10. Conduct innovative supervision

Source: *MOHSW and PMORALG: Functions of Regional Health Management System (August 2008)*

Japan International Cooperation Agency